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ABSTRACT

This monograph contains several commissioned papers which attest to the significance of the family perspective in the understanding, treatment, and prevention of drug abuse. Papers discussing the fundamentals of a conceptual framework for the family perspective are followed by a review of theories of family growth and development, structure, function, and dysfunction, including reports of supporting research and case materials. Policy considerations for local treatment programs, state and federal initiatives, and the professional community are discussed. The monograph concludes with conceptual shifts and subsequent proposals that may institutionalize new ways of thinking about dysfunctional behavior. A report of the Office of Program Development and Analysis on the practice of primary prevention in family therapeutic work is included. A recurring theme throughout these papers is the supposition that specific family-related antecedents are associated with specific problematic behavior, that certain generic family factors are associated with dysfunctional behavior, and that investigations of the apparent commonalities would be useful. (Author/NRB)

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DRUG ABUSE FROM THE FAMILY PERSPECTIVE

Coping is a Family Affair

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Foreword

We have been impressed to find that this collection of commissioned papers, each separately developed, achieves a convergence of opinion on the connection between the family and drug abuse. The very evident theme of agreement among such a sophisticated professional group conveys the forceful message that the American family is a vibrant and powerful collective force capable of dramatically influencing the behavior of its members.

The papers unequivocally attest to the significance of the *family perspective* in the understanding, treatment, and prevention of drug-abusing behavior. We hope this monograph will intensify the process of integrating family factors into the policies and practices of drug abuse treatment programs across the country.

Richard A. Lindblad, Dr. P.H.
Director
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Preface

Much of the early work in the drug abuse field represented an attempt to explore relationships between drug dependence and associated variables focused on the individual psychodynamics of persons with drug problems. More recent investigations have begun to examine drug abuse as dysfunctional behavior in the context of the family system.

It has not been clearly established by the National Institute on Drug Abuse how much emphasis should be placed on family factors vis-a-vis drug-abusing behavior. There is emerging interest, however, in family issues with respect to other kinds of dysfunctional behavior (e.g., alcoholism, schizophrenia, some psychosomatic disorders). In commissioning the papers included in this monograph, the Office of Program Development and Analysis (OPDA) was seeking professional confirmation of the soundness of NIDA's expanding activities around family issues as they influence and are influenced by drug-abusing behavior.

The authors selected have professional experience with drug abusers, as well as special interest in and knowledge about the family. The original group commissioned to write for the monograph included psychiatrists, psychologists, a sociologist, a nurse, and social workers. Forty percent were female. In keeping with our intention to have the monograph reflect a diversity of culturally determined family factors, those commissioned represented major racial/ethnic groups as well as the dominant culture. The monograph reflects the pluralism in this country though not to the extent originally desired, inasmuch as four persons from the original group did not submit papers.

There are different points of view from which the family can be studied. In the guidelines for the contributors we emphasized the clinical perspective, as distinct from that of sociology or cultural anthropology. We pointed out that we had no fixed notions about family membership or structure, that we recognized and appreciated the one-parent family and the extended family, as well as the culturally determined traditional family. We established broad parameters with respect to specific topics relevant to the overall theme of the family

and drug abuse, inviting the authors to develop their thinking in one or more of the following areas:

1. Aspects of their clinical or research experience that substantiate a family-focused approach to the understanding, treatment, or prevention of drug-abusing behavior;
2. The relationship between culturally specific family considerations and drug-abusing behavior, as viewed from a particular racial/ethnic perspective and based on the author's experience, practice, or research.

In the drug abuse field the number of published authorities on the family is relatively small. (Some of them are contributors to this monograph.) It is not surprising, then, that several of the papers refer to the same authorities and occasionally present similar data. We do not see this as redundancy; rather, we view it as both appropriate reinforcement of important material and validation of the work of the experts cited.

Readers will find discussions of theory, reports of research, and policy implications for State, local, and national programs and for researchers. Several authors present case illustrations; also, one author demonstrates the efficacy and utility of combining traditional with more recent approaches to therapy. We include a report of OPDA's 1978 workshop on the practice of primary prevention in work with the family as the unit of focus. There is also a provocative examination of differing philosophies of reality within which dysfunctional behavior can be viewed, along with evidence and conviction that where competent families are found, substance abuse is seldom found. The document covers the abuse or misuse of a range of licit and illicit drugs and examines the phenomenon of drug dependency in families that occupy different positions along the socioeconomic scale.

Each paper can stand alone as an affirmation of the significance of family factors in understanding and dealing with drug-abusing behavior. The monograph has been organized, however, to allow readers to experience a somewhat sequential development of the theme. The volume begins with the fundamentals of a conceptual framework for the family perspective, further setting the stage with theories of family growth and development, structure, function, and dysfunction, including reports of supporting research. The case material that comes next illustrates and confirms many of those theories and findings. Policy considerations then follow logically—for local treatment programs, for State and Federal initiatives, and for the professional community. The monograph concludes with some conceptual shifts and consequent proposals that have the potential for institutionalizing new ways of thinking about dysfunctional behavior. In-

deed, readers who make use of the opportunity for the conceptual reframing of drug abuse and other problematic behavior within the family context will find their way of thinking about dysfunctional behavior forever changed.

Finally, readers will find a recurring idea that is directly expressed in some papers, more subtly in others. This is the supposition that there are specific family-related antecedents associated with specific problematic behavior, and certain generic family factors associated with dysfunctional behavior irrespective of category, and that investigations of the apparent commonalities would be fruitful for the mental health field.

Barbara Gray Ellis

1. Some Overlooked Aspects of the Family and Drug Abuse

M. Duncan Stanton, Ph.D.

In recent years, the importance of the family in the genesis, maintenance, and alleviation of drug problems has received increasing recognition. A number of literature reviews (Harbin and Maziar 1975; Klagsbrun and Davis 1977; Salmon and Salmon 1977; Seldin 1972; Stanton 1979b, 1979d, 1979e) and over 370 related papers (Stanton 1978a) have emerged. People in the field have come to realize that, unless one takes an extreme genetic or sociological view of addiction, drug problems develop within a family context and most abusers are not isolates who have no primary ties. In other words, problems that arise in abusers' lives can usually be linked to the interpersonal forces and relationships that surround them. While it is not disputed that many other factors (e.g., environmental, physiological, economic, conditioning, and genetic) can also be critical, family variables have come to assume a position of salience in the arena of addictive symptomatology.

CONCEPTS OF THE FAMILY, SYMPTOMS, AND TREATMENT

Before proceeding to the specifics of drug abuse, it is important to provide some conceptual clarification vis-a-vis the family and the role of symptoms within it. A major problem that has existed both in the drug abuse area and in the larger field of mental health has been the simplistic view of the family that has predominated. Except for consideration of the early developmental years, the family has been

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viewed as a more or less inert influence which, at worst, can bring additional "stress" on the symptomatic member. However, its importance in symptom *maintenance* has generally gone unrecognized. In instances where the family *is* mentioned, discussion has usually been couched in, for example, mother-addict or father-addict dyads, or in terms of the characteristics of these people as individuals; the concept of the family as a *system* of people composed of the members *and* their interactions has rarely been applied. Such individually and dyadically oriented concepts are not really in tune with what we have learned about families over the past 20-25 years.

Related to the above is the role of the symptom, per se, within the family system. A symptom can be seen as a particular kind of behavior that functions as a homeostatic mechanism regulating family transactions (Jackson 1965), i.e., it maintains the dynamic equilibrium among the members. It is a communicative act that serves as a sort of contract between two or more members and often occurs when a person is "in an impossible situation and is trying to break out of it" (Haley 1973, p. 44). The person is locked in a sequence or pattern with the rest of his family or significant others and cannot see a way to alter it through nonsymptomatic means (Stanton 1978b, 1979c). More specifically, the symptom may help, for instance, in the labeling of a member as helpless and incompetent and, therefore, unable to leave home. It might serve as a problem that unifies the family and keeps it intact, much as a catastrophe unites people who experience it together. Similarly, it might have diversionary qualities, drawing the attention of other members to the symptom bearer and away from their own difficulties. These are just a few of the functions a symptom can serve within a family homeostatic system.

Lennard and Allen (1973) have emphasized how, in order for drug abuse treatment to "take hold," the social context of the abuser must be changed. Applying this to the family, one could assert, as have Bowen (1966), Haley (1962), and others, that in order for the symptom to change, the *family system must change*. Conversely, treatment that changes an individual must also have effects on his interpersonal system. However, if broader system change (rather than change primarily in the individual) does not occur, the chances for prolonged cure are reduced, for there can be considerable pressure on the "improved" symptomatic member to revert back to old ways. This idea has important implications for the way in which drug abuse treatment is approached.

We are dealing here with events and behaviors that often lie outside the purview and experience of most treaters and researchers; the actions of family members other than the symptom bearer are rarely or only occasionally observed within the context of most conventional

programs. When the larger system actually is encompassed, we must make a conceptual leap into new ways of thinking about symptoms such as substance abuse. Such a view is radically different from and discontinuous with individually or intrapsychically oriented cause-and-effect explanations. It is a new orientation to human problems. Einstein stated that the theory to which we subscribe determines what we see, and it is hoped that through application of this different perspective the reader will be better able to understand the material to follow.

ADDICT FAMILY PATTERNS AND STRUCTURES

It is beyond the scope of this paper to cover the extensive body of demographic, psychosocial, and interactional literature that has accumulated on the families of drug abusers. This has been done in the aforementioned reviews. Instead, a brief overview will be given of the predominant patterns and structures that have emerged from the body of existent research. Their relevance for treatment will also be noted. Emphasis here and throughout this report will be on findings about families in which a member shows heavy, compulsive drug use rather than occasional or experimental use.

Family of Origin

Drug misuse appears initially to be an adolescent phenomenon. It is tied to the normal, albeit troublesome, process of growing up, experimenting with new behaviors, becoming self-assertive, developing close (usually heterosexual) relationships with people outside the family, and leaving home. Kandel et al. (1976) propose, from their data, that there are three stages in adolescent drug use and each has different concomitants. The first is the use of legal drugs, such as alcohol, and is mainly a social phenomenon. The second involves use of marijuana and is also primarily peer influenced. The third stage, frequent use of other illegal drugs, appears contingent more on the quality of the parent-adolescent relationship than on other factors. Thus, it is concluded that more serious drug misuse is predominantly a family phenomenon.

The importance of adolescence in the misuse of drugs becomes more apparent when family structure is considered. The prototypic drug abuser family—as described in most of the literature—is one in which one parent is intensely involved with the abuser, while the other is more punitive, distant, and/or absent. Usually the overinvolved, indulgent, overprotective parent is of the opposite sex of the abuser.

Sometimes this overinvolvement even reaches the point of incest (Cuskey 1977; Ellinwood et al. 1966; Wellisch et al. 1970). Further, the abusing offspring may serve a function for the parents, either as a channel for their communication, or as a disrupter whose distracting behavior keeps their own fights from crystallizing. Conversely, the abuser may seek a "sick" state in order to position himself, childlike, as the focus of the parents' attention. Consequently, the onset of adolescence, with the threat of losing the adolescent to outsiders, heralds parental panic. The family then becomes stuck at this developmental stage and a chronic, repetitive process sets in, centered on the individuation, growing up, and leaving of the "identified" patient.

It is probably most helpful to view the above process as at least a triadic interaction, minimally involving two adults (usually parents) and the abuser. If the drug-using youth is male, mother may lavish her affections on him because she is not getting enough from her husband, while husband retreats because his wife undercuts him—for example, when he tries to appropriately discipline the son. This kind of thinking is much more attuned to the family system, and only a few studies and papers have subscribed to it. Schwartzman (1975) notes how all members help to keep the drug addict in a dependent, incompetent role. Alexander and Dibb (1975, 1977), Huberty (1975), Noone and Reddig (1976), Reilly (1976), and Stanton, Todd, and Associates (1979) present data on how the family serves to undermine the drug abuser's self-esteem, and how drug taking helps to maintain family stability and homeostasis. Stanton et al. (1978) conceptualize drug taking as serving the dual function of simultaneously letting the addict be distant, independent, and individuated, while at the same time making him or her dependent, in need of money and sustenance, and loyal to the family. They have called this "pseudoindividuation."Even as an adult the drug user may be kept closely tied into the family, serving much the same function as during adolescence when the problem (probably) had its onset. This model of compulsive drug use fits much of the data and helps to explain the repetitiveness of serious misuse and the continuity both (a) across generations, and (b) throughout much of a compulsive user's own lifetime. While there is evidence for more frequent substance abuse among parents of drug abusers, relative to parents of nonabusers (see Stanton 1979b for a review), the view presented here accentuates the importance of the identified patient in the family versus his/her siblings. The limitations of a simple "modeling" theory of drug abuse are underscored, since a particular offspring is usually selected for this role; all children in a family are not treated similarly. Even if they all have equal opportunity to observe the drug-taking patterns of their parents, they generally do not all take drugs with equal frequency. Modeling parents' behavior is only a partial explanation of drug taking by their children.

It is not necessarily obvious that addicts in their late 20s and early 30s would still be involved with their families of origin. Their age, submersion in the drug subculture, frequent changes in residence, possible military service, etc., all seem to imply that they are cut off, or at least distanced, from one or both parents. However, there is increasing evidence that, despite their protestations of independence, the majority of addicts maintain close family ties. Even if they do not reside with their parents, they may live nearby, and the frequency of contact is high. Twenty years ago Mason (1958) noted the overinvolvement between male addicts and their mothers. This phenomenon was also hinted at by Chein et al. (1964) and was documented in an early study by Vaillant (1966b) in which he found that 72 percent of the addicts in his sample still lived with their mothers at age 22. When those whose mothers had died prior to the addict's 16th birthday were deducted, the percentage rose to 90 percent. As late as age 30, 47 percent were living with a female blood relative (59 percent when corrected for those with living mothers). Ellinwood et al. (1966) also noted a tendency for male addicts to be living alone with their mothers, while Thompson (1973) reported that an increasing and substantial minority of the addicts in Vancouver, B.C., remained with their parents. Noone and Reddig (1976) found that 72.5 percent of their 323 clients (average age 24.4) either presently lived with their families of origin or had done so within the previous year. Andreoli (1978) has stated that at least 80 percent of the heroin addicts in Italy live with their parents, and a similar percentage has been noted by Choopanya for addicts in Thailand.[1] In tracking addicts for long-term followup, Bale et al. (1977) noted addicts usually have a long-standing contact such as a parent or relative, and Goldstein et al. (1977) reported that addicts "tend to utilize a given household (usually their parents) as a constant reference point in their lives" (p.25). These authors give examples of how even the "street" addict periodically gets in touch with his permanent address, renews relationships with his family, etc.

Along these lines Coleman noted in an examination of the charts of 30 male heroin addicts that the person they requested to be contacted in case of emergency was invariably the mother, and was almost never the person with whom they lived, i.e., wife or girlfriend, for clients who did not live with their mothers.[2] A 1972 survey of our own (Stanton 1978c; Stanton et al. 1978), taken among 85 addicts at the Philadelphia Veterans Administration Hospital Drug Dependence Treatment Center and using anonymous questionnaires, found that of those with living parents, 66 percent either resided with their parents or saw their mothers daily; 82 percent saw at least one parent weekly. These

[1]K. Choopanya, Health Department, Bangkok, Thailand, personal communication, April 1978.

[2]S.B. Coleman, personal communication, March 1979.

figures become more striking when one realizes that the average age of these men was 28 and all of them had previously been separated from home and in the military for at least several months. The least frequent contact rate was among those over age 35. The only dissenting study on this point was performed in Vancouver by Alexander and Dibb (1975), who felt that most addicts were not closely tied to their parents. However, they did not obtain family contact data but only inspected existing records to see where, at intake, former patients reported they were living. It is our experience, and that of Noone and Reddig (1976), that this method is highly unreliable in that much depends on the focus of the intake interviewer. Also, if an addict does not want his parents contacted, or has reservations about the program, he may provide an incorrect or alternative address, such as that of a girlfriend. Further, Ross (1973) found that addicts tended to operate out of two addresses, one of which was "drug-related" and the other "family-related," and it is quite possible that many of Alexander and Dibb's subjects may have reported the former when providing intake information. In sum, this is a facet of the addict family pattern that has not generally been recognized, partly because many addicts deny this closeness or tend to protect their parents. However, anonymous questionnaires or observations of actual behavior have, for the most part, yielded data consistent with a close addict-family tie hypothesis.

Family of Procreation

Concerning marriage and the family of procreation, it has generally been concluded that the (usually heterosexual) dyadic relationships that addicts become involved in are a repetition of the nuclear family of origin, with roles and interaction patterns similar to those seen with the opposite-sex parent (Harbin and Maziar 1975; Seldin 1972; Taylor et al. 1966; Wolk and Diskind 1961). In a certain number of these marriages both spouses are addicted, although it is more common for one or neither of them to be drug dependent at the beginning of the relationship (Fram and Hoffman 1973; Wellisch et al. 1970). If the marital union is formed during addiction, it is more likely to dissolve after methadone treatment than if initiated at some other time (Africano et al. 1973). Also, nonaddicted wives tend to find their husbands' methadone program to be more satisfactory than do addicted wives (Clark et al. 1972). Equally important, the rate of marriage for male addicts is half that which would be expected, while the rate for multiple marriages is above average for both sexes (O'Donnell 1969). Chein et al. (1964), Scher (1966), and Stanton, et al. (1978) have noted how parental permission is often quite tentative for the addict to have a viable marital relationship. Although he attempts flight into marriage,

there is often a certain pull or encouragement for him to go back. Consequently, he usually returns home, defeated, to his parents.

Comparison With Other Symptoms or Disorders

Since a number of disorders, in addition to drug abuse, show a pattern of overinvolvement by one parent and distance/absence by the other, the question arises as to how the families of drug abusers differ from other dysfunctional families. In a recent paper, Stanton et al. (1978) have tried to clarify this issue, drawing both from the literature and from their own studies.[2] In brief, the cluster of distinguishing factors for addict families appears to include the following: (a) a higher frequency of multigenerational chemical dependency—particularly alcohol among males—plus a propensity for other addictionlike behaviors such as gambling and watching television (such practices provide modeling for children and also can develop into family "traditions"); (b) more primitive and direct expression of conflict, with quite explicit (versus covert) alliances, for example, between addict and overinvolved parent; (c) parents' behavior characterized as "conspicuously unschizophrenic" in quality; (d) the addict may have a peer group or subculture to which he/she (briefly) retreats following family conflict—the illusion of independence is greater; (e) mothers who display "symbiotic" childrearing practices further into the life of the child and show greater symbiotic needs than mothers of schizophrenics and normals; (f) a preponderance of death themes and premature, unexpected, or untimely deaths within the family; (g) the symptom of addiction provides a form of "pseudoindividuation" at several levels, extending from the individual-pharmacological level to that of the drug subculture. Finally, there are data to indicate that offspring of people who immigrated either from another country or from a different section of the United States have high addiction rates, so acculturation variables and parent-child cultural disparity may play a major role in the development of drug addiction (Alexander and Dibb, 1975; Stanton 1979a; Vaillant 1966a, 1966b).

TREATMENT AND THE DRUG ABUSER'S FAMILY

Family Factors That Neutralize Treatment for Drug Abuse

From the early papers (e.g., Berliner 1966-67; Hirsch 1961; Mason 1958; Wolk and Diskind 1961) to the present, many writers have at-

[2]The reader is referred to the original paper for the references that document these conclusions.

tested to the importance of the family in the maintenance of addiction. Not only is the drug taking of one member often overlooked by relatives, it is frequently either openly or covertly encouraged (Harbin and Maziar 1975; Klagsbrun and Davis 1977; Seldin 1972; Stanton 1979d; Thompson 1973; Wellisch and Kaufman 1975). Further, in addition to supporting the drug-taking pattern, the family may actually work to sabotage those treatment efforts that begin to succeed in reducing or eliminating it. Examples of this have been commonly reported in the literature, such as the wife of the recovering alcoholic who buys him a bottle of liquor for his birthday, or the parent of the heroin addict who gives him money to purchase drugs. Thus, the family is crucial in determining whether or not someone *remains* addicted.

Addicts who are married or living with a spouse-type partner are involved in at least two intimate interpersonal systems—that of the "marriage" and that of the family of origin. Since more time is spent in the marital context, this system would appear to be more influential in maintaining the drug pattern. A number of writers (e.g., Gasta and Schut 1977; Wellisch et al. 1970) have emphasized the importance of drugs in many such relationships, and Hejinian and Pittel (1978) give data indicating that while addicts' spouse-type partners generally voice strong support for the abuser's abstinence, there is also evidence for an unconscious collusion to remain addicted. However, our own studies (Stanton and Todd 1979; Stanton et al. 1978; Stanton, et al. 1979) have underscored the interdependence between the marital couple and one or both of their respective families of origin.

In line with the observations of Chein et al. (1964) and Scher (1966), we have observed that a "rebound" effect often occurs from marital quarrels, resulting in the addict returning to his parents. We have found that couples therapy often brings stress on the marriage and triggers another rebound, so that treatment has to begin by including both systems; the key is to start with the parental-addict triad and move more toward the family of procreation in accordance with the parents' readiness to "release" the addict (Stanton and Todd 1979; Stanton, et al. 1978).

Several investigators have looked at family effects on posttreatment adjustment. For example, Vaillant (1966b) found that a high percentage of heroin addicts returning to New York City from the Federal drug program at Lexington, Kentucky, went to live either with their mothers or a female blood relative; the rate of readdiction in this group was also very high. Thompson (1973) noted a similar pattern. Zahn and Ball's (1972) data with Puerto Rican addicts indicated that cure was associated with living with one's spouse, while noncure tied in with living with one's parents or relatives. Stanton et al. (1978, 1979) observed that prognosis was better for addict families in which the

parents were most easily able to release the addict to spouse or outsiders during the course of treatment.

Positive Family Influence

While the above discussion deals with ways in which the family can neutralize the treatment effort, family involvement can also prove beneficial (Dell Orto 1974). The inherent leverage of significant others can be used to help the drug-abusing member *overcome* his problem, rather than serving as a force that *maintains* it. To this point, Eldred and Washington (1976) found in interviews with 158 male and female heroin addicts that the people the patients thought would be most helpful to them in their attempts to give up drugs were the members of their families of origin or their in-laws; second and third choices were an opposite-sex partner and the patient himself or herself. Other researchers (NIDA 1975) found in interviews with 462 heroin addicts that the family was second only to treatment (70.9 percent vs. 79.6 percent) as the influence they perceived as most important in changing their lives. Finally, Levy (1972) indicated in a 5-year followup of narcotic addicts that patients who successfully overcame drug abuse most often had family support.

Family Treatment

Concerning nondrug-related disorders, the field of family therapy appears to have come of age. Dozens of books, hundreds of articles, and five journals exist in the area. In a review of the literature, Gurman and Kniskern (1978) located over 200 studies of family or marital treatment that presented outcome data. Of those in which family therapy was directly compared with other modes of treatment, it emerged with superior results in two-thirds of the studies and equal results in the remainder. Gurman and Kniskern also noted that, among the various schools of family therapy, the most impressive findings have been obtained with a structural approach (Minuchin, 1974) corresponding, in general, with results that have emerged with family therapy in the drug abuse field (Stanton, 1979d).

Family treatment is a relative newcomer to the field of drug abuse. However, it has found rapid acceptance. Data from a recent survey of 2,012 drug treatment facilities by Coleman and Davis (1978) indicate that the majority of our Nation's drug abuse treatment programs provide some kind of family services—in many cases family or marital therapy—as part of their therapeutic armamentarium. In at least 40 of these programs, involvement of the family is mandatory (Coleman and Stanton 1978).

Recently Stanton (1979d) has reviewed the literature on family treatment for drug problems. Seventy-four papers were located, pertaining to 68 different studies or programs. A number of approaches were used, such as multiple-family therapy, couples groups, etc., but the largest proportion employed conjoint family therapy, i.e., treatment of individual families. Most of the papers held that such approaches are beneficial and effective. Eight of the 68 mentioned the efficacy of their techniques without providing data, 20 presented case studies with outcomes, and 14 quantified their outcomes. Six of the 14 involved comparisons with other forms of treatment or control groups. Four of the six (Hendricks 1971; Scopetta et al. 1979; Stanton 1978c; Stanton et al. 1979; Wunderlich et al. 1974) showed family treatment to be superior to other modes, while the remaining two (Winer et al. 1974; Ziegler-Driscoll 1977, 1978) obtained equivalent, or equivocal, results. The author concludes that family treatment shows considerable promise for effectively dealing with problems of drug abuse.

FAMILIES WITH LITTLE OR NO DRUG USE

Clues as to the reduction and prevention of drug misuse can be obtained from studies of families who rarely or never use drugs. A number of reports present data on control or "normal" families. In comparison to drug-using families, the nonusing or low-use families show the following characteristics: offspring perceive more love from both parents, particularly father (Mellinger et al. 1975; Streit et al. 1974); there is less discrepancy between how the parents would ideally like their children to be versus how they actually perceive them, and children are seen as more assertive (Alexander and Dibb 1977); parents and their offspring's friends are compatible, parents have more influence than peers, less approval of drug use is voiced by parents and peers (Jessor 1975); more spontaneous agreement is observed in problemsolving, but if it does not occur, members are slower but more efficient in reaching solutions (Mead and Campbell 1972); they function more democratically or quasi-democratically, with shared authority and better communication (Cannon 1976; Hunt 1974).

In her study of white middle-class, nondrug-using families, Cannon (1976) also found them (a) better able to prepare their children for adult life than families of drug-using adolescents; (b) more likely to deny their negative feelings or, perhaps, feelings in general; (c) more likely to make the best of existing circumstances and underplay frustrations; and (d) generally more cohesive. In addition, she noted that they showed more rigidity than the norm and attributed this to the fact that a majority of them were referred for participation in the study by religious groups.

Finally, the work by Blum and Associates (1972) led to a number of conclusions about families that were at low, medium, or high "risk" for drug misuse. The low-risk families manifested a "benevolent dictatorship" structure with diversity of self-expression and adherence to traditional sexual roles. They also showed the following: religious involvement, along with love of God and country; more emphasis on childrearing, discipline, self-control, and less allowance of freedom for children; emphasis on family togetherness and cohesion; greater ability to plan and have fun together; offspring more enamored of control and obedience, and also reliable, honest, and sensible. An important variable was their sense of family tradition, i.e., that the family had existed over generations—an ethos that seemed to engender loyalty to family standards. It was noted that some of them tended to "have adamant beliefs that status quo is right, that racial segregation is desirable, and that those who want social change are menaces," while some offspring were found lacking in flexibility and were "smug, dogmatic, subservient, uninspired and uninspiring" (p.105). The authors posit that some of the moderate-risk families showed better adaptation because, even if their offspring had engaged in minor drug experimentation, they appeared to be rather self-reliant, flexible, zealous, curious, and not overly dogmatic, neurotic, or sociopathic. These families tended to "give in" somewhat in childrearing, but maintained a basic firmness.

PREVENTION

Family Treatment

Of the various approaches to psychotherapy—whether for drug abuse or other problems—family treatment has perhaps the clearest implications for prevention. This is because (a) more people are involved when one sees a family; (b) it engages people (e.g., parents) who may not otherwise have entered treatment themselves, but who engender problems in others (e.g., offspring); and (c) if effective, a system is changed which, prior to treatment, had the potential to produce problems in other offspring. For instance, if parents are helped to improve the ways in which they handle a son or daughter with a problem, they are becoming more competent parents. Their experience will hopefully provide them with ways of dealing with younger children as these grow older, i.e., the lessons learned with one offspring can be transferred to others. In fact, the work of Klein et al. (1977) with delinquents indicates that family therapy can result in clear-cut prevention of future problems among siblings. Further, if the family situation is changed so that a drug abuser is set free of the

needs of his parents and therefore, in part, his need for drugs, he is on the road to becoming a more competent person, and in the long run a more competent spouse and parent himself. This, then, is primary prevention.

Education

Several years ago Blum (1972) opined that drug education has rarely helped young people's decisionmaking about use. A subsequent review also concluded that this approach is generally ineffective or equivocal in reducing overall drug use, although some programs may attenuate more extreme use by certain individuals (Bry 1978). However, a recent report by Resnik (1978) indicates that drug information, in small doses, can be effective, especially if it is presented *in a family setting.* Similarly, Stanton (1979b) has stated that education for prevention needs to be aimed more directly at parents and families, as opposed to, for example, school systems. It should be based on a sophisticated knowledge of family patterns, structures, and childrearing practices. Information on such topics as dealing with grandparents, how to allow an adolescent autonomy, and when to be firm, might be appropriate. Familial triads and larger units should be discussed, rather than perpetuating such limited individual and dyadic concepts as the "personality" of the drug user, or the mother-son relationship. The adaptive role that drug use can serve in the family could be dealt with, in addition to warnings, for instance, of how antagonisms between one parent and a child may arise if the parents are divided. Emphasis needs to be placed on strengthening the *boundaries between the generations.* Parents should be helped to recognize how their child, in an effort both to get his or her own way and to survive, can play them off against each other if they are not of a similar mind on disciplinary procedures. Finally, the positive ways that families can deal with drug-related problems should be stressed, and a sense of hope should be conveyed. For, indeed, there does appear to be hope.

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2. Incomplete Mourning in the Family Trajectory: A Circular Journey to Drug Abuse

Sandra B. Coleman, Ph.D.

INTRODUCTION

Theoretical explanations for drug-abusing behavior are abundant. They are also confusing, for the tenets of one theory often contradict and refute those of another. In addition, the term "drug abuse" is not uniformly defined; its meaning is largely a function of each author's idiosyncratic point of view. It is important to acknowledge that there are numerous ways of accounting for drug abuse. Lettieri's (in press) extensive review separates the major explanatory concepts into four general categories: (1) psychological theories—one's relationship to self; (2) psychosocial theories—one's relationship to others; (3) sociological theories—one's relationship to society; and (4) naturalistic theories—one's relationship to nature. This paper seeks to explore one aspect of psychosocial theory—the role of the family in encouraging, reinforcing, and sustaining drug-seeking behavior. The term "drug-abusing family" applies to families with at least one member engaged in compulsive drug use in a manner suggesting physical and psychological dependency; further, that member's lifestyle is characterized by a continuous drive to obtain and use drugs. Thus, the general focus is on narcotics, mainly heroin, and the distinguishing family properties and processes purported to be associated with drug abuse.

As background, this paper provides an overview of drug-abusing

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families from a family systems perspective. First, a general introduction to systems theory will be given with representative examples from drug-abusing families. A brief review of relevant research literature is followed by an investigation of the role of death, separation, and loss as a central theme among these families. In conclusion, implications for treatment, research, and prevention are discussed.

THEORETICAL PERSPECTIVES

Family Systems Theory

The conceptual foundations of family systems theory are derived from general systems theory (von Bertalanffy 1968). In contradistinction to a closed, static, nonhuman system, the family is an open, living, and dynamic system that is a function of certain principles and processes that support and maintain its basic structural unit. In order to apply family systems theory to the field of drug abuse it is necessary to understand its core concepts. The following constructs are regarded as central theoretical components of family systems theory; some have been previously described as particularly relevant to the field of substance abuse (Steinglass 1976; Stanton 1977a; Stanton and Coleman 1979).

The Family System

A system is a set of interdependent objects or members that together comprise a whole unit, i.e., the family. Each subset or member affects and is affected by every other member of the system. Thus, each action on the part of one member creates a sequence of further actions and reactions on the part of other members that imposes a rippling effect on the unit as a whole. A systems theory explanation of drug-using behavior suggests that the abusing member represents a functional need of the family system and is a symptom of the *family* process rather than an expression of the intrapsychic need of the individual. The events that precede the drug use and the behavioral context within which the substance abuse occurs are important determinants of the drug's function within the family.

Family Homeostasis

Homeostasis refers to the family's ability to regulate or balance and stabilize itself (Jackson 1957). It may serve functional or dysfunctional purposes. When the family's usual balance is disrupted by a new situation the system must make appropriate modifications and adjust-

ments. If the change is productive for the family, a new adaptive homeostatic condition should result. If pathological behavior occurs in the face of change, the positive effects may be threatened and the former homeostatic pattern could prevail. An example might be a drug-abusing family that attends two family therapy sessions with resultant drug abstinence. They cancel further appointments and the drug taking is resumed.

Homeostasis is dependent on *feedback loops* that operate within the family system as well as externally. An example of an internal feedback loop is found when a drug-using adolescent male comes home late for dinner appearing to be "high." Father confronts him with his suspicions, but son denies using drugs. Father becomes more attacking and "grounds" son. Mother intercedes and tells father that he should not punish son without more evidence. Father then becomes engaged in an argument with mother, and son disappears. When mother enters, the situation between father and son is redirected; the conflict shifts from parent versus child to husband versus wife. Mother's intervention frees son to return to drugs, thus restoring the homeostatic pattern which can be expected to be recycled and reenacted when son returns home. Each sequence of behavior contributes to the internal feedback loop which is probably a familiar and repetitive family theme.

Family Roles

Each family member has assigned roles that directly relate to the functional organization of the family. In healthy families these roles are mutually supportive and provide an environment for growth and positive interpersonal transactions. A healthy family system is open to the external environment that facilitates the flow of energy and information back to the family as a constructive resource. Such interchangeability and flexibility enhance the family's structure and functioning, a process sometimes referred to as *negentropy*. When internal/external boundaries are either too permeable or too rigid, energy sources become blocked or flooded, creating massive structural disorganization, chaos, and potential system disintegration. Such a system is closed and represents a state of *entropy*. Families with severely addicted members are very entropic and are frequently described as being "enmeshed." A common dyadic enmeshment occurs between the male heroin addict and his mother. The addict becomes stuck in his role as the "identified patient," where he remains unless new energy is permitted to enter the system. When roles are too fixed and rigid, entropic conditions also exist. This state results in family "disengagement," which lies at the other end of the

continuum from enmeshed systems. Both situations are comprehensively discussed by Minuchin (1974) and are particularly relevant to drug-abusing families.

Reference to the family *scapegoat* is frequently made; in drug abuse literature this role is assigned to the drug-using family member. As already discussed, drug use is viewed as a function of the family system, and although one person may act as the "carrier," the other members are active contributors to the pathology. The scapegoat or "identified patient" is the sacrificial member who uses drugs in the service of the family (Boszormenyi-Nagy and Spark 1973). As previously described (Stanton 1977a; Stanton and Coleman 1979), the symptomatic member in the family draws attention to him/herself and his/her problem, which brings the family together in an effort to contend with the difficulties. Coleman (1975) views this as the participatory function of drug abuse and suggests that drug abuse is analogous to a slow-dying process wherein the dying member is invested with special status. Thus the demise is both sacrificial and noble (Coleman and Stanton 1978a; Stanton 1977b).

Intergenerational Coalitions

Within problem families intergenerational boundaries are often loose. Most characteristic is the split loyalty demonstrated when one parent is in a coalition with a child, leaving the other parent "triangulated." The concept of the triangle is sometimes considered as basic to all animal societies. As Bowen (1978) postulates, " . . . the triangle, or three person system is the molecule or building block of any relationship system." He suggests that when more than three people are involved, the system is composed of a sequence of interlocking triangles. Triangular relationships are often referred to as "triadic" systems (Jackson 1957; Haley 1967, 1973). The most frequent triadic pattern in unhealthy systems, particularly among drug-abusing families, is that of husband, wife, and child. In the previous example, the cross-generational coalition between mother and son led her to defend him while simultaneously stripping her husband of his right to confront their son. Her alliance with her son was greater than her loyalty to her spouse, which left him floundering on the tip of the triangle. His own inability to hold his position of parental power reinforced the collusive bonding in the mother-son dyad. As Stanton et al. (1978) observe, drug abuse research has finally progressed beyond the point of merely focusing on the obvious parent-child subsystem and now looks for the triadic element within family interaction.

In summary, these concepts provide a background for understanding the foundations and principles within which drug use becomes an

expression of family structure and function. Within the context of these theoretical underpinnings, drug abuse as a family phenomenon can be more extensively explored.

DRUG ABUSE AND THE FAMILY

Drug use as a "family affair" was a phrase used by Huberty (1975) in his 1974 presentation before the North American Congress on Alcohol and Drug Problems in San Francisco. The role of the family in supporting the use of drugs by one of its members is a critical issue currently being addressed by a growing number of people. The use of family therapy in rehabilitating drug abusers is a relatively recent treatment approach. In part this innovation has evolved because the rate of recovery from addiction has consistently remained low. Despite the burgeoning development of therapeutic communities, drug abuse treatment units in community mental health centers, psychiatric hospitals, and storefront drop-in centers, most treatment outcome has been only temporarily successful. The most common forms of treatment have failed to provide a viable means of preventing people from returning to drugs and their associated lifestyle. For example, Dell Orto (1974) states that the original motivation for initiating group therapy for families and drug abusers in a therapeutic community was "... the realization that treating drug abusers apart from their families was an exercise in futility."

There is an emerging trend among drug counselors to engage families in the therapeutic process. A recent national survey of family therapy and drug abuse (Coleman 1976; Coleman and Davis 1978) indicates that 93 percent of the sample population of respondent agencies ($N=2,012$) were involved in providing some type of family therapy to clients. Despite the apparent widespread interest in working with families, Coleman's study consistently reports an inverse relationship between the degree of opiate abuse and the quality and quantity of family therapy, i.e., low-opiate groups get more family therapy, a more adequately trained family therapist, and an agency that fosters family therapy as a central mode of drug rehabilitation.

An instrument designed to assess an agency's relative sophistication and experience in family therapy (Coleman and Stanton 1978b) further indicates that although many people are working with families, the degree of family therapy skill is questionable. Most of the therapists had approximately 3 years of family therapy experience, but still did more individual and group therapy than family therapy (Coleman and Kaplan 1978).

Other recent research and literature reviews on therapy with drug-abusing families (Brown et al. 1973; Callan et al. 1975; Reilly 1976;

Hirsch and Imhoff 1975), and the structural and dynamic characteristics of addict families (Stanton 1977c; Davis 1977; Seldin 1972) are worthy of discussion, but such an effort is beyond the scope of this paper. The remainder of the paper will examine the significance of unresolved separation and loss in families in which drug abuse is a problem. It is important to note that the following material must be considered within the context of multidimensional interlocking processes; the emphasis given here does not necessarily exclude other significant sequelae relative to familial history and interpersonal transactions.

Death, Separation, and Loss

Separation Issues

The enmeshed quality often observed in drug-abusing families suggests that considerable anxiety surrounds the issue of separation/individuation. This phenomenon is further supported by studies showing that addicts frequently remain at home with their families of origin until they are in their late 20s and early 30s. Even when they do not live with their families, they are often in contact with them on a daily or weekly basis. Vaillant (1966) found that 72 percent of the addicts in his sample population continued to live with their mothers until they were at least 22 years of age. Many remained at home until they were in their 30s. Stanton et al. (1978) investigated this characteristic of the addict family and found that 66 percent of a sample of 85 addicts in treatment at the Philadelphia Veterans Administration Drug Dependence Unit were either living with their parents or saw their mothers daily; 82 percent saw at least one parent on a weekly basis. The mean age of these men was 28, and all of them had been away from home for at least a short period of time while serving in the military forces.

Attardo's (1965) study of mothers of addicts, schizophrenics, and normals revealed that the addicts' mothers had greater symbiotic needs than either of the other two groups. This was particularly evidenced when the addicts were 11-16 years of age. Coleman (in press) found that drug counselors report a marked difference in perceived "best" and "worst" periods of life among a group of heroin addict clients. Among the four developmental age periods, the years 0-5 and 6-12 were consistently considered as "best" while the "worst" periods were between 16-19 and 20 and over.

The national survey of family therapy in the field of drug abuse (Coleman 1976) also found that separation and loss were frequently reported as important correlates of families with drug abuse problems. Further, a comparison of characteristics of drug abusers from different ethnic families suggests that a common element is that of loss and

separation due to divorce, marital separation, or death. One of the most striking types of loss exists among the Navajo, who are in danger of losing their religious rituals to the new revivalist sects. A dispute with the Hopi also threatens them with a severe land loss with concomitant loss of large numbers of livestock. Navajo counselors feel that the stripping of cultural needs exacerbates and contributes to addiction. One sensitive worker said, "Unless the Indian can keep his rituals he will most assuredly die" (Coleman 1979).

Among all cultures separation conflicts heighten during adolescence, which coincides with the time when drug abuse is often intensified. This is frequently attributed to the family's generalized fear about separation. Since the major task of adolescence is to prepare to separate from the family in order to achieve competence and independence, drugs offer a convenient vehicle for avoiding adulthood, i.e., remaining incompetent and dependent. Stanton et al. (1978) suggest that these families have a chronic, repetitive pattern of the addict member leaving home only to fail and return; this reflects the whole system's anxiety about separation and individuation. The authors view this as an "interdependent process" in which the addict's failure is a means of protecting and maintaining family closeness. Further, they believe that heroin is a paradoxical solution that allows the addict to remain straddled between home and the outside world of drugs. Thus, the addict acquires "competence in a framework of incompetence."

Death and Loss Issues

The relationship between death and drug abuse is gaining increasing attention. In addition to the high death rates and low life expectancies among drug addicts (Ferguson et al. 1974; Vaillant 1966a) the indirect suicidal aspects of drug abuse are particularly salient. Frederick (1972) and Stanton (1977b) suggest that the high death rate among addicts is to a great extent suicidal in nature. As far back as 1938 Menninger described addiction as "chronic suicide." Others have also viewed drugs as a suicidal equivalent (Cantor 1968; Litman et al. 1972).

The direct relationship between the incidence of family deaths and drug abuse has been suggested by Blum (1972), who found that high-risk families had a greater frequency of death among the grandfathers of addicts when the fathers were young. Miller (1974) associated drug abuse with the loss of a parent or significant other, e.g., peer. He viewed drug abuse as a defense against the threat death imposes to an adolescent's own feelings of immortality, and proposed that the infantile sensations of omnipotence induced by drugs help the individual to deal with the loss.

Coleman (1975) investigated the histories of 25 addict families seen

in family therapy. Her primary purpose was to determine the prevalence of death in two generations, i.e., the family of procreation and the family of origin. Severe or life-threatening illnesses were also studied because critical illness is so often followed by death. Only the untimely, premature, or unexpected deaths were quantified; deaths resulting from normal aging processes were not included in analyzing the data. Thus, the majority of deaths included in the study took place during the addicts' or parents' developmental years.

Results indicated that although some families felt the impact of more than one death, 18 (72 percent) experienced at least one traumatic or unexpected loss of a loved one. Seventeen (68 percent) were witness to a severe or unusual illness, and a similar number of families had an alcoholic parent or sibling in either of the two generations studied. When the variables were combined, 13 families (52 percent) experienced death and severe illness, and 12 families (48 percent) were found to have death and alcoholism in their backgrounds. Eleven (44 percent) of the families had a combination of illness and alcoholism, but when alcoholism was subsumed under the category of illness, there were 24 families affected. The latter figure suggests that 96 percent of all the families studied were in some way affected by either alcoholism or some other chronic debilitating illness. Nine families (36 percent) experienced a combination of death, illness, and alcoholism, which accounts for over one-third of the sample. Although this was not a controlled study, these data suggest that this is an area that needs further systematic investigation.

Coleman (1978, in press) provides further clinical evidence of the significance of death to addict families. She found that death and death-related issues were major themes in her group therapy sessions with siblings of recovering addicts. In addition to talking about death, this small group of 20 preadolescents experienced several of their own traumatic family deaths during the course of the 2-year project. Noone and Reddig (1976) focus on a case study of an addict whose major conflict was the loss and grief associated with the impending death of his mother. The authors suggest that " . . . drug abuse is an intensified expression of loyalty to the family system" (p. 329).

Perhaps the most impelling view of family loyalty is described by Stanton (1977b) who sees the addict as the sacrificial member who nobly acts out the family's wish for the addict's death. Stanton suggests that in the role of "savior" the addict fulfills the system's need for a martyr and thus becomes a dramatic participant in the family's suicidal conspiracy.

In studying the role of death in addict families, Coleman and Stanton (1978) view the addiction as taking on a special participatory meaning. They suggest that the drug-abusing member is treated as one who is undergoing a slow death. The idiosyncratic manner in

which these families emphasize this "dying" process is felt to arise from unresolved and premature deaths experienced by the family, particularly the drug addict's parents. The addict thus becomes a substitute for the deceased. Coleman and Stanton offer several methods of dealing with these death issues within family therapy sessions, which allow the death issue to serve as a vehicle for constructive family change.

Stanton and Coleman (1979) consider the indirect self-destructive behavior of drug abuse from an interpersonal/familial context. They comprehensively reviewed the literature on issues related to drug abuse and death and interpret the indirect self-destructive nature of drug abuse as adaptive, functional, noble, sacrificial, and understandable when viewed within its interpersonal context. The authors develop a "homeostatic model," based on a complex set of feedback mechanisms that involve, as a minimum, a triadic family subsystem, most likely mother, father, and drug abuser. This is a circular model in contradistinction to the linear or causal chain of family events—a premature death in the addict's parents' family of origin, leading to phobic-like separation anxiety and conflict in the family of procreation, establishing a dependent versus counterdependent environment within which the drug abuser struggles to achieve adulthood.

The circular model is based on the kind of behavior exemplified in the earlier section on homeostasis and feedback loops. With regard to the death issue, the family's incomplete mourning of a deceased member keeps the parents in a continuous sort of grieving process. Because they have not mastered the loss, the drug abuser becomes the "revenant" of the dead person and is encouraged to stay close to the family. When he/she attempts to leave home, a family crisis will ensue and he/she will be "called back." As Coleman and Stanton (1978a) and Stanton et al. (1978) suggest, these families would rather have the addict dead than to lose him/her to outsiders. The "moving in and moving out" of the addict serves a family maintenance function. It is part of a cycle of interlocking behaviors and if the addict actually dies, another member will most likely start to use drugs, preserving the family's need to remain enmeshed in an endless cycle of mourning, loss, and mourning.

IMPLICATIONS FOR TREATMENT, RESEARCH, AND PREVENTION

Treatment techniques must focus on shifting the homeostasis by restructuring the family patterns. Triadic relationships can be

"detriangulated" by increasing the strength of generational boundaries. For example, in the mother-son versus father episode, mother either must remain indirectly outside the father-son confrontation or must overtly align herself with her husband. Either move strengthens the marital relationship and forces the son to face his drug abuse as *his* problem to embrace or reject.

Clinical interventions that directly deal with unresolved death issues have been described in the Coleman and Stanton (1978a) article. The above example of realigning the marital pair *excludes the issue of death* but nonetheless weakens the fear of the son's demise by shifting the family balance and underscoring the support between the marital pair.

The authors also suggest that the family can be *confronted with the reality* that death is a likely consequence of using drugs, *plan the funeral*, and *plan the postmortem events*. Somewhat paradoxical in style, these approaches exaggerate the death theme and help the family to mobilize in order to prevent death from becoming a self-fulfilling family prophecy. Other suggested interventions are to *allow the drug to die* instead of the addict, to have the family *visit the grave site* of the deceased ancestor and to therapeutically "talk" to him/her, or to use a technique where the family *confronts the "ghost"* within the context of the family therapy session. A case example of this is provided in the original paper.

Research efforts are essential in order to gain systematically derived data to support or refute the prevailing theoretical material. The drug abuse field is now sophisticated enough to isolate the characteristic psychosocial family variables that are most predictive of drug abuse. It is important to know whether the incidence of death, separation, and loss is significantly different in drug-abusing families. In addition to finding discrete measures of loss, the intervening behavioral transactions among family members prior and subsequent to their losses must be investigated. Feedback loops in drug-abusing families need to be compared with the cyclical patterns in other deviant as well as healthy families.

There is some evidence from the Lewis et al. (1976) study that healthy families have a greater capacity to deal personally with death. Their findings support Paul and Grosser's (1965) suggestion that dysfunctional families avoid dealing with loss. More to the point presented here is Eisenstadt's (1978) notion that " . . . loss triggers off a crisis requiring mastery on the part of the bereaved. If the crisis is worked through, that is, if the destructive elements and the depressive features of the experience of bereavement are neutralized, a creative product can result" (p.220). Eisenstadt suggests that a major intervening variable in the relationship between the death of a parent and the

desire for fame, eminence, and occupational excellence is the nature of the family unit prior to the disruption caused by a parental death. As conceptualized here, the only mastery that the drug abuser can achieve is that derived from the world of illicit drugs. It is here that he/she gains eminence vis-a-vis the immortality attached to martyrdom. Unlike Eisenstadt's subjects who lost at least one parent during childhood, creatively mastered their loss, and gained eminence in later life, the drug abuser remains entrenched in the family's grief, using drugs as a coping device. Most significant are the *intervening family coping mechanisms* that either facilitate the creative process and lead to the acquisition of occupational excellence, as Eisenstadt suggests, or destroy it by substituting compulsive drug-seeking behavior as one's avocational claim to posterity.

Implications for primary prevention can be derived from the conceptual issues presented here. The clinical interventions used in treating the whole family unit have potential preventative benefits for younger, nondrug-using siblings who should derive optimal advantages from the structural and dynamic family changes. Also, increased efforts to develop groups for siblings of drug abusers could redirect or halt the intergenerational transmission of drug- and alcohol-abusing behavior. Although the positive effects of sibling groups are maximized when they are implemented in conjunction with family therapy, they are still a viable alternative when circumstances preclude working with the entire family unit.

In addition to concentrating on pathological or high-risk families, all families need to be provided the opportunity to "work through" bereavement. Community-based institutions such as funeral parlors and hospitals are uniquely capable of offering seminars and therapy groups on death and dying to those whose needs are most immediate. A pilot project to study long-term effects of such a program would be of considerable value to the entire mental health field. If families attend sessions together, their interpersonal connections would undoubtedly be strengthened, thus preventing the kind of enmeshed quality that flourishes in a conflicted, insecure environment.

This paper presents a view of the drug-abusing family as a closed system of interlocking patterns and transactions that are determined by complex, multifaceted elements. There has been an emphasis on the circular relationships that tend to support and produce an intergenerational legacy of drug abuse. As a final note it is important to realize that all family life is cyclical in nature. Just as an individual's personal "passages" are imbued with predictable, "normal" crises, both healthy and unhealthy families encounter certain expected stress points at varying ages and stages. Perhaps what is most remarkable in drug-using families is that they seem to have a unique manner of cop-

ing with life's continuum—it is their idiosyncratic, repetitive, and self-regulatory familial arrangements that have been of particular interest here.

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3. Hispanic Family Factors and Drug Abuse

Leida Ileana Collado-Herrell, Ph.D.

Two topics that have had profound impact on the mental health professions in the 1970s have been drug abuse and "the family." Although much of the public hysteria over drug use has abated, the use of drugs has not. Marijuana has insinuated itself into our culture to such an extent that many adolescents simply no longer consider it a "drug"; cocaine seems to be achieving the same status. If the popular media now tell us little about LSD, scarcely an evening passes without a PCP psychosis being transmitted into 30 million homes during prime time. During the last decade millions of dollars have been spent educating about and against drugs; more millions have been spent in various treatment programs. Numerous studies have enhanced our knowledge about drug use and abuse without increasing our understanding of it appreciably.

Many have looked to the family to find understanding. The family—or more often, the breakdown of the family—has become the all-purpose explanation for almost everything that is wrong in the 1970s. The contention that the family is breaking down and the corollary that the breakdown underlies society's ills are seldom questioned, despite equivocal definitions of terms and data supporting such contentions.

This paper will examine the relationship between drug abuse and the Hispanic family in three stages:

- A discussion of conditions of family functioning, accompanied by a limited review of relevant recent literature that deals almost entirely with research and theories about white and native English-speaking Americans;
- A discussion of the application and relationship of these data to the Hispanic cultures in the United States; and

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- A listing of recommended directions for future research, prevention, and treatment programs in behalf of Hispanics with, or at risk for, a drug problem.

SOCIALIZATION AND FAMILY STRUCTURE

The view of the family and its impact on children that is presented in this paper draws heavily on social learning theory (e.g., Bandura and Walters, 1963; Blechman 1978), and on the family therapy models of Haley (1978) and Minuchin (1974). These approaches contribute to understanding the socialization process and family factors that account for its success and maintenance.

Borrowing from Blechman, four very general propositions may be stated summarizing the social learning position on socialization.

1. The amount of observational learning by a child from parents depends upon—
   - Parent *availability*—opportunities for the child to observe the parent;
   - Child *attention* to the parent; and
   - *Consequences* to the child for imitating the parent, including self and other-delivered consequences.
2. The quality of observational learning by the child depends on the competence of the parent and the competence of alternative models.
3. Parental influence on children is a combination of *direct* influence on the child and *indirect* influence through control of the child's access to alternative sources of influence.
4. Anything that strengthens parents' social reward *power* will promote parental influences; conversely, factors that weaken this power will dilute parental influence and heighten the child's susceptibility to alternative models. This power, in turn, will depend upon both parental *dominance*—that is, the capacity to reward, and parental *nurturance*—the inclination or tendency to dispense rewards.

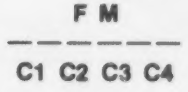
Thus, parents who are *available* (physically present), who are *competent*, and who have *and use* the capacity to dispense social rewards, will have the greatest positive influence on their children, and will maintain greater influence directly and indirectly compared with alternative reward sources. Factors that limit parental availability and competence, and interfere with or impede rewarding parent-child interaction, will lessen parental influence and render children more vulnerable to outside and potentially negative influence. Several circumstances may serve to limit parental influence; for instance, poor psy-

chological functioning of individual parents, unfavorable economic and unemployment factors, or an unstable family structure or disrupted hierarchy.

Although no attempt will be made here to describe comprehensively the principles of family structure, a few basic concepts will be presented.

Hierarchy

Families have levels of power, or authority, which are usually characterized as vertical, or hierarchical. "Hierarchy" refers to the vertical layers of authority within the family. Ideally, the parents exist at one level, and above the level of the children as shown in the diagram.[1]



Executive (Parental) Subsystem

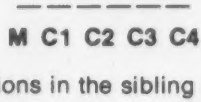
This subsystem consists of the parents, who function both as spouses and as parents. Parents should be hierarchical peers.

Sibling (Child) Subsystem

This subsystem consists of the children. It may be further subdivided by sex or by age (older and younger children).

Disturbed Hierarchy

A disturbed hierarchy is one with a mixing of subsystems. Most typical is a hierarchy with generational mixing, e.g.:



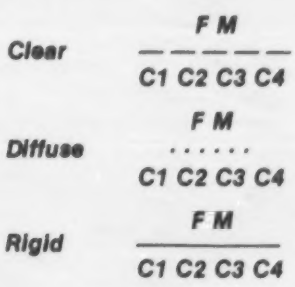
Here, the mother functions in the sibling subsystem and the father assumes all executive roles.

Boundary

Boundaries are the rules governing family interaction—who partici-

[1] Diagrams used here are after Minuchin (1974) and are used with permission of the Harvard University Press.

pates, with whom, and under what circumstances. Boundaries help differentiate subsystems, and all the subsystems, to function properly, require clear boundaries. Boundaries must be clear enough to protect the subsystem but permeable enough to allow interaction between members of different subsystems. Boundaries may be characterized as:



Coalition

A coalition is a rigid, inappropriately constituted subsystem. Coalitions are usually cross-generational, for instance:

Here, the mother and a child have formed a coalition against the father. The hierarchy has been violated, mother-child boundaries are diffuse, and communication between the two subsystems has become difficult.

Enmeshed Family

Such a family becomes excessively concerned with itself and its members. Communication between members is extensive, as are expressions of concern. Contact with systems outside the family is diminished. Boundaries and hierarchies become blurred, subsystems merge. System "overload" occurs and the family is vulnerable to stress. Within enmeshed families relatively minor problems in one family member are treated by the entire system as a crisis.

Disengaged Family

Alternatively, families may become overly rigid; members communicate little with other members, subsystems are isolated, and levels of

concern and adaptive protective functions are reduced. In disengaged families, one member's problems must reach crisis proportions before the family system responds to it.

SOME FAMILY-RELATED BASES OF DRUG ABUSE

The reasons for drug abuse are numerous but may be conveniently grouped into three categories:[2]

1. Self-medication/sensation-seeking;
2. Peer pressure and acceptance; and
3. Symbolic protest.

Self-Medication/Sensation-Seeking

Drug use may begin and be maintained through the pharmacological impact of the drugs used. Users may frequently attribute their use to the calming or tranquilizing properties of drugs, or their stimulating properties, or their power to distort reality. Use of licit and illicit drugs by parents for "medicinal" purposes—to calm the anxious or stimulate the depressed—has been consistently related to drug use in their children (Braucht et al. 1973; Braconnier and Olievenstein 1974; Gorsuch and Butler 1976). Thus it appears that the self-medicating function of drug abuse may, in part, stem from imitation of parental reliance on medication. From the above propositions concerning imitation, it would follow that the more visible the parental medicating, and the more parents encourage and support use of medications by children, especially for minor problems, the greater the propensity of children to abuse drugs for their "medicating" potential.

The sensation-seeking function has been documented (Gorsuch and Butler 1976; Kay et al. 1978) but presents less clear correlates to family factors. It may be proposed that the role of sensation-seeking in initial drug use, or experimentation, is related to the ebullient, self-confident, adaptive aspect of seeking new experiences; however, continued use of drugs as a form of excitement may relate to more basic psychological factors stemming from deprivation and narcissism (Zukerman 1971). Certainly the syndromes of early parental deprivation and narcissism are established as underlying some drug abuse (Sullivan and Fleshman 1975-76; Lidz et al. 1976; Viani et al. 1976).

[2] This listing closely follows the model of Kohn and Annis (1978), although their use of left-leaning sociopolitical values as a determinant is not included due to its limited applicability; further, their use of the sensation-seeking orientation ignores the "self-medicating" aspect of drug abuse—for instance, the tranquilizing effect some may seek through illicit drugs.

Peer Pressure and Acceptance

No factor has been more clearly documented as a principal basis of drug use than peer pressure (Ball 1969; Gorsuch and Butler 1976; Wright 1977). It is, of course, an insufficient explanation for continued participation in a behavior as seriously problematic as drug abuse. Family influences may be the mediating factors in determining why a youth resists, succumbs to, or identifies with "deviant" peer pressures.

The *availability* of parental models is a key variable. Parents may be unavailable in any of several ways. First, a parent may not be present due to death or separation or divorce. Numerous studies have found that a large percentage of drug abusers have experienced the loss of a parent (Braucht et al. 1973; Braconnier and Olievenstein 1974; Sullivan and Fleshman 1975-76; Lidz et al. 1976; Viani et al. 1976). As Blechman has noted (Blechman et al. 1977; Blechman 1978), single-parent homes have more strength than is commonly supposed, and parent loss itself is not a powerful determinant of drug abuse. However, in single-parent homes where the remaining parent is insufficiently competent to serve as an adequate model, or where economic circumstances or social policy limit the physical availability of the parent or inhibit expression of competence, problems are more likely to occur.

Parental unavailability may also occur even when both parents remain in the home, when working hours keep them away. In other families where parents are in the home but are indifferent to their children, they are unavailable as models for adaptive behavior. Conditions such as these not only reduce the availability of parents to serve as models, but also reduce the opportunities the parents have to dispense rewards, leaving the children (adolescents) particularly vulnerable to peer pressure. Even when both parents are present, defects in the family structure may diminish the productive influence (power) of the family over that of the peer group, rendering the child more susceptible to peer influence. Parental rejection (failure of parents to dispense rewards) may have as a consequence the seeking of rewards outside the family; hence, peer acceptance becomes more important.

A frequent research finding (Braucht et al. 1973) has been that drug abusers have come from families characterized by under- or over-domination (analogous to disengaged and enmeshed families). In the case of underdomination, the family hierarchies and boundaries are too fluid and ill-defined, and the presence and use of reward power are weak and inappropriate. Socialization to the deviant peer group provides some sense of structure. In the case of overdomination, hierarchies and boundaries are too rigid, power may be coercive, and

reinforcement may be negative rather than positive. In such cases deviant subcultures offer freedom. Finally, as has often been noted (Braucht et al. 1973), binds and lack of clarity in communication are typical in families of drug abusers. While under the influence of drugs, communication is distorted, the most inane of comments seems profound, and pseudoempathy within a group of drug users is common. Hence, persons from poorly communicating families may find comfort in drug use, where need for effective communication is reduced.

Symbolic Protest

Many adolescents attribute drug use to their desire to protest—against their parents, schools, or society generally (Kay et al. 1978; Kohn and Annis 1978). Adolescent rebellion as a basis for drug use was rather romantically popularized by Kenniston (1967). But adolescent rebellion is seldom clearly political in nature and when it does occur, it occurs most often in children from families already left-leaning sociopolitically (Sears 1968; Gorsuch and Butler 1976; Kohn and Annis 1978). In any event, the symbolic protest function of drug abuse does not appear to be a powerful explanatory concept. While many persons engaged in protest may also use drugs, it is unlikely that significant numbers of persons select drug abuse as a specific mode of protest, although they may find it convenient to pretend to have done so.

A final family characteristic frequently cited as present in families of drug abusers is the ineffectual, or "subdominant" father (Braucht et al. 1973; Sullivan and Fleshman 1975-76). The presence of a "weak father" can have several potentially negative consequences. Coupled with a competent mother, a weak father will create a pathogenic family structure, where the mother and father do not share the executive role, where the father is hierarchically at or below the level of the children, or where the father subverts the mother's efforts to manage the family. The weak father may serve poorly as a model for socialization; the children may then socialize to an inadequate model. A caveat is appropriate here. For a couple of decades it was fashionable to attribute inappropriate behavior in children to inadequate mothering. Attributing drug abuse to inadequate fathering is a conceptual move laterally, not forward. The concept of the subdominant father could divert attention from the family *system* as surely as did the concept of the schizophrenogenic mother. The system of relationships between combinations of parents and children, while more complex, should prove a more fertile field than characteristics of individual parents.

HISPANIC FAMILY CHARACTERISTICS

The following section will address the relevance of the preceding material to Hispanics, who constitute the second largest minority in the United States. There are 12 million[2] Hispanics now in the United States, and it is projected that Hispanics will become the Nation's largest minority within a decade (U.S. Commission on Civil Rights 1976). Some studies have noted startlingly high rates of drug abuse among Hispanics, especially in urban areas (Rivera 1975; Padilla et al. 1977).

In seeking understanding of Hispanic factors related to drug use it is necessary to delineate the ways in which Hispanic families tend to differ from other American families. First, it is crucial to note that the concept of "family" is different in Hispanic cultures. "The family" is a more meaningful concept for Hispanics, one invested with more emotional intensity (Collado-Herrell 1976). Loyalty to one's family and physical proximity to its members are especially highly valued by Hispanics (Szapocznik et al. 1978). The definition of "family"—who is and is not a member—tends to be broader for Hispanics, who will include as "family" not only the nuclear family, the extended family of grandparents, aunts, uncles, and cousins, but also godparents (the compadrazgo concept), and even friends and neighbors. Further, unlike the historical American, Jeffersonian attitude in which each generation is on its own, Hispanic cultures place more value on their deceased forebears—on their lineal heritage. Traditional Hispanics may feel a closeness with long-dead relatives, whereas in a traditional American family one would have no knowledge of relatives more than a generation or two removed (Collado-Herrell and Villanueva, in press). Place of birth also exerts a powerful hold on Hispanics (Canabal and Goldstein 1975). The experience of the Hispanic away from home is so complex as to defy simple labeling—there is, for instance, no single Spanish synonym for "homesickness."

Not only does the Hispanic concept of family differ in significant ways from that of the modal United States culture, but so also do attitudes toward drug use, mental health, and mental illness. Drug use is viewed by native English-speaking Americans as more complex, with positive and negative components; among Spanish speakers, it is

[2] The 12 million figure is subject to dispute. Hispanic groups have noted at least three reasons for regarding that figure as an underestimate. First, the formal census failed to survey all Hispanics; second, the three million Puerto Ricans in Puerto Rico are not included; third, undocumented aliens are not included in the count. While not contributing to the census, these overlooked Hispanics may indeed "contribute" to the population of drug abusers.

more uniformly perceived as "bad." The connotation given to "mental illness" by Spanish speakers is in the direction of "crazy" (loco), whereas native English speakers give it a meaning in the direction of "illness." And, compared with native English-speaking Americans, speakers of Spanish attribute more respect to "doctors," including "psychiatrists," without necessarily believing in their skills (Szalay and Deese 1978).

A summary of generalized differences between Hispanic families and English-speaking American families will be helpful before proceeding. Compared with non-Hispanic-American families, in Hispanic-American families—

- Authority relationships are emphasized more strongly;
- Concepts of personal dignity (dignidad) and respect (respeto) are strong;
- Males are inculcated in "macho" (stereotypical masculine) values;
- Females are reared to be submissive and to sacrifice themselves for their own families;
- The extended family—including godparents, friends, neighbors, and dead relatives—has particular salience; and
- Place of birth is important.

HISPANIC FAMILY FACTORS AND DRUG ABUSE

Reference was made earlier to three categories of reasons for drug abuse. These categories are examined now in relation to Hispanic family factors that are especially significant.

Self-Medication/Sensation-Seeking

It has been noted that some Hispanic cultures (in this case, Puerto Ricans) tend to somaticize problems and to seek relief through medication (Abad et al. 1977). Collado-Herrell (1977) has demonstrated the pain-reducing function illegal drugs serve for Puerto Rican users. The factors underlying the self-medicating function of drug use, as described previously, also apply to Hispanics—i.e., such behavior may grow out of imitation of parental reliance on medication.

The sensation-seeking function of drugs among Hispanics was specifically investigated and found *not* to be a factor in either black or Hispanic drug users, although it was for whites (Kaestner et al. 1977). Abad et al. (1977) noted the cultural normativeness of "pseudohallucinations" (for instance, contact with deceased relatives or delusions of being transported back home each night) among Puerto Ricans, and the adaptive function these phenomena may have.

Pseudohallucinations certainly are consistent with the familial and geographical ties of Hispanics and could be aided by hallucinogenic drugs, although this speculation is based on indirect evidence.

Peer Pressure and Acceptance

Peer pressure has been shown to be a powerful influence in drug use among Hispanics (Ball 1969; Zermeno-Alvarez et al. 1976). The *availability* of parental models is of great importance, but among Hispanic families in the United States certain conditions serve to weaken the opportunities for adaptive modeling. Hispanic families, compared with the national averages, are larger (more children), younger, and more likely to have a female head-of-household (U.S. Civil Rights Commission 1976). This results in fewer adults and more children with whom to identify and from whom to learn, and less parental availability per child. For the poor, the heightened contact with social agencies may serve to diminish the perceived competence of the parents (Blechman 1978).

Further, the (widely) extended family has positive and negative benefits. The nurturing effect is described by Rivera: " . . .(H)is family is extensive. Each person knows his neighbors and depends on family and friends for support in crisis situations. A child is reared to feel that he is never alone, that all around him is a network of sustaining relationships" (1975, p.99). At the same time, the multiple extensions, into different locations, different families, and different generations, promote blurring of hierarchies and boundaries. The opportunities for cross-generational coalitions are greater. "Family satellites" may be formed within the family, a phenomenon shown to be common in families of drug users (Viani et al. 1976). Under favorable circumstances the extended family can be a source of strength and nurturance; under other circumstances it may be a source of confusion and a training ground for manipulation, and may lead to pursuit of security with one's peers. Children from unstructured extended families are at greater risk for socialization into deviant subcultures.

Another apparent risk of intense family relations and of expanded and diffuse family relationships is that family and cultural *values* may more easily be transmitted than the *strengths* to implement them, especially when the individual is removed from the source of cultural support. Thus, it is noted (Braucht et al. 1973) that first generation "ethnics" are particularly at-risk for drug abuse. Migration and social mobility, which separate people from their families and birthplaces, produce special difficulties for Hispanics (Zermeno-Alvarez et al. 1976; Abad et al. 1977). Finally, language difficulties play a role (Padilla and Ruiz 1973); lack of English fluency results in difficulty in

identifying with the modal culture, produces barriers to friendships, and leads to discrimination from members of the modal (English-speaking) culture. Hence, opportunities for successful adaptation are reduced, as are the number and variety of peers with whom one may relate. Discrimination faced by one's parents may reduce the child's perception of parental competence, thereby reducing positive parental influence.

Symbolic Rebellion

Brenner et al. (1970) have noted that rebellion does indeed play a role for Puerto Rican drug users. However, in contrast to the mainstream middle class who rebel against middle-class *values*, Puerto Rican poor rebel against their *inability* to become part of the mainstream.

Rebellion may also occur against families. The young Hispanic in the United States is often caught between parents with strong emotional ties to other cultures and another language, and the modal or core culture that is seen on television dominates the educational system and controls access to the presumed benefits of American culture. A first-generation Hispanic child may perceive his parents as imposing an alien language and culture upon him, and rebellion may be a way of coping with the resultant conflict.

Finally, the educational system may serve as a focus of rebellion for the Hispanic. The insistence by many school systems on exclusive use of English conveys to many young people an implied denigration of the native (Spanish) language and culture and, by extension, denigration of the individual. Thus, when drug use is related to rebellion, the foci of rebellion may include the educational system which, wittingly or not, serves to reduce self-respect and cultural identity; the family, which promotes a language and culture that may be alien to the child; or the larger society, which limits access to resources. It must be stressed that forced acquisition of English and mandatory abandoning of Spanish serve—in the minds of children—to devalue Spanish, and to separate the child from his family and culture.

IMPLICATIONS

Prevention

Traditionally, prevention approaches have been of the educational and hortatory variety; that is, efforts have been aimed at the citizenry to

teach the effects of drugs, the symptoms of drug abuse, where to go for help, etc. Various prominent persons in the pop culture—e.g., football stars—have exhorted the young to avoid drugs. It is clear that educational efforts must reach Hispanic cultures in the language they speak, the places they gather, and in ways to which they can relate. Similarly, hortatory efforts must include Hispanic sports stars (for instance) or other Hispanic luminaries.

A number of social issues relevant to the context of this paper could have an impact on drug abuse among Hispanics through impact upon Hispanic families and traditions. Generally, any social policy or action that weakens the Hispanic family, or prematurely or arbitrarily forces a schism between the Hispanic and his culture, will increase the likelihood of drug abuse. For instance, social and welfare agencies may, however benevolent their intent, force service recipients into status and behavior circumstances that lower parental opportunities to display competence and to exert appropriate parental control (Blechman 1978).

U.S. immigration policies, particularly those regarding undocumented aliens, create special problems for large numbers of Hispanics in this country. Under the most favorable of circumstances migrant cultures are at risk; they are separated from home of origin, face daily economic uncertainty, and are often divorced from cultural and linguistic supports. Illegal migrants face the additional problem of constant "fugitive" status that serves to make dangerous those activities that otherwise would be most helpful, such as participation in the local Hispanic communities, involvement in cultural celebrations, religious activities, etc. Since immigration raids are often directed at ethnic restaurants and festivals, social groups, or sports activities, undocumented aliens cannot participate openly or fully in these events. Further, public health and educational opportunities are few for this population, all of which serves to heighten the likelihood of problems such as drug abuse among these aliens and in their children.

Treatment

Looking to the family to help understand the origins of drug use, one will also find a potent source of treatment for the drug abuser. Family therapy is proving to be an effective method of treating many problems, including drug abuse in Hispanic families (Szapocanik et al. 1978; Hägglund and Pylkkänen 1974; Minuchin et al. 1967). Some residential or group home programs are operating along family models (see Simpkinson and Platt 1979).

While Minuchin et al. (1967) have shown structural family therapy to be useful with the Puerto Rican poor, there remain certain additional

guidelines concerning family treatment of Hispanics that are independent of specific approaches.

Authority

Hispanics grant a great deal of authority to the therapist; and the therapist should use it. Heightened authoritarianism is a characteristic of many Hispanic drug users; emphasizing authority patterns within the family will often be productive.

Hierarchy

Related to the authority concept, the idea of hierarchy is critical within Hispanic families. The primacy of parents may be reinforced and at the same time respect paid to cultural values. Reinstatement of the hierarchy must be accomplished before successful differentiation may occur.

Lineality

The allegiance to the family can be productively used in therapy. The therapist should validate the family role.

Special attention must be paid to the complete extended family. Restructuring of a portion of it may lead to the identified patient (drug abuser) leaving that segment of the family and entering another (Szapocznik et al. 1978; Rivera 1975).

A task-oriented, present-time focus will be most helpful.

Research

There are certain areas where more research seems redundant. There already exist sufficient data (Braucht et al. 1973; Gorsuch and Butler 1976) detailing differences between families with and without a drug abuse problem, and findings are quite consistent. Even the less extensive literature on Hispanics is reaching a point of diminishing returns, so that "shotgun" approaches are no longer useful. Research should focus on specific areas.

In studying Hispanic family factors related to drug abuse, these areas could be given attention:

- There are several Hispanic cultures in the United States, most numerously Puerto Ricans, Mexican-Americans, and Cubans. How do these groups differ and how are they the same? What cultural and family similarities and differences are there?

- "Length of stay" in this country has been suggested as a crucial variable, with migrants and first-generation Hispanics in the United States particularly at risk. More definitive work should be done on the time-in-country factor.
- In a therapy vein, what techniques prove to be most useful?
- One study suggested culturally unique sex differences among Hispanics (Mexican-Americans), the opposite of sex differences found among other American therapy patients (Long et al. 1977). Further investigation of these sex differences could prove useful.
- Limited drug experimentation is the norm among adolescents in the United States. Some adolescents experiment and are never discovered; others are caught by parents, police, or school officials. What are the consequences of detection? How do families react, and are reactions related to subsequent use? As Minuchin (1967) has noted, some families (enmeshed) consider it a tragedy if a child skips dessert; other families (disengaged) may handle an adolescent pregnancy without a blink. Does this mode of functioning relate to drug use after detection? Are there cultural differences?

SUMMARY

In order to view family factors in drug use and abuse from a cohesive framework, a synthesis of principles from social learning theory and structural family therapy was presented; research was reviewed. The special case of Hispanic-Americans was considered. The Hispanic definition of and attachment to the family present interesting contrasts with those of the modal American culture, but family factors appear to be strong determinants of drug use among Hispanics. Implications were listed for prevention and treatment of drug abuse and for future research.

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4. Family Therapy and the Chicano Drug Abuser

Robert L. Campos

When I began working in the field of drug abuse treatment in the early 1960s one of my first patients was a Spanish-speaking woman in her early twenties, heavily addicted to heroin. The woman was seen briefly as an outpatient prior to being admitted to a hospital for detoxification. On discharge she did well for a few weeks before becoming addicted again. She returned, accompanied by her brother who was also addicted to heroin. The brother was admitted, and the sister was able to withdraw as an outpatient. Following discharge the brother and sister did well for a few weeks. Predictably they were both readdicted soon and returned for treatment.

This time, however, they were accompanied by a tearful, hysterical mother, who dramatically knelt at the feet of the therapist and pleaded for help. Both brother and sister were hospitalized again. Again they withdrew successfully and were discharged to outpatient therapy. Again the scenario was repeated: two heavily addicted, confused, contrite siblings and a pleading, all-suffering mother, begging for help for her two children. At this point I may have been more confused than the patients were, but I finally realized that there was more to this problem than met the eye. I began to interview the mother and children and, to my amazement and professional embarrassment, started to see the vital importance of the dynamics of family systems. It appeared that when brother and sister were home and nonaddicted, mother would hover over them, asking if they were getting sick, if they felt a stomach ache, if they had cramps, wiping their brows of real or imagined perspiration. At the first sign of any induced withdrawal symptoms she herself would go and buy heroin for them. Her reason? "I love my children dearly and don't want to see them suffer."

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This story, which is a true one, has an interesting ending. I began seeing all three in therapy together. The brother and sister did well. Both moved out of the house, married nonaddicted mates and were still unaddicted several years later. The mother also married again—to a much younger man heavily addicted to heroin.

Family therapy would seem to be the treatment of choice for the majority of drug abusers. Two issues should be kept in mind, however. First, family therapy as a clearly identified treatment model is relatively young and is still undergoing modification and refinement.[1] To complicate things further, the literature regarding family therapy approaches for the Mexican-American family is almost nonexistent at this time. This is not to say that this modality is not used with this population, but rather that it is a relatively new one that holds great promise.

The second issue to be kept in mind is that drug abuse treatment other than for opiate and alcohol abuse is also relatively young. It was not until the mid-1960s that concentrated Federal efforts were channeled into the treatment of drug abuse. Drug abuse treatment programs have now become almost a growth industry with concomitant problems regarding the efficacy of the myriad treatment approaches currently in vogue. It goes without saying that it behooves the funding agencies as well as people in the field to evaluate their treatment efforts.

This paper will address the issues of family therapy with families of Mexican-American drug abusers. It is only in recent years that workers in the field have been applying family therapy techniques to the Chicano family. I will offer a collection of personal experiences over the past 12-15 years in the field of drug abuse treatment. My training in family therapy has been modified over the years to adapt to the unique needs of mono- and bilingual Spanish-speaking families, who are "special" families.

THE NEW MEXICAN SPANISH FAMILY

Just as the Mississippi black is different from the black in the South Bronx, who is different from the black in Watts, so, too, is the Cuban in Miami different from the Puerto Rican in New York, who is different from the Chicano in East Los Angeles, who is different from the Mexican in Texas. This section will concentrate on the Spanish-speaking families of New Mexico. For the sake of brevity the term "Chicano" will be used.

[1] An excellent review and critique of family therapy has been developed by Olson (1970).

The influence left 300 years ago by the early Spanish settlers in New Mexico still remains. The silent war between those traditions and the rapidly eroding influences of the larger Anglo-American culture has played havoc with the Chicano family. The traditional powerful authority of the father is at odds with the encroachment of the new style of women's liberation.

> The father is expected to be strong and forceful, a good provider, who remains somewhat aloof and distant. Because of belief in the value of discipline for children's own good, the father may administer verbal or physical harm to his sons. His authority cannot be questioned. The mother in the family is more permissive and is a source of love and reassurance. The Spanish family is patrilineal, descent being reckoned through the father's family, including especially his relatives and/or "compadres" (co-parent). Within the family, brothers are ranked by age, the first-born son having authority over younger siblings. In the absence of his father or upon his death, the eldest son takes over the responsibility for the rest of the family. Girls are under control of the mother until marriage, and this code is rarely broken by older tradition. Brothers exercise protective vigilance over the welfare and reputation of their sisters.
>
> Within this extended family, the individual finds not only support, but his personal identity. Inequality is observed ceremoniously and also the dominant and submissive roles appropriate to the individual's place in the society. There is considerable preoccupation with the concept of family honor and the respect of one's fellows. This continues to be a major point of adult male behavior.
>
> In the hierarchical authoritarian structure of the family, the individual has no equal in the family. He is either superior or inferior to the other members. Therefore, New Mexicans go outside of the family to find true companionships. Friendships formed in the early years are deep and long lasting, and friends have the obligation of reciprocal help.[1]

Jaramillo has further developed an excellent concept of the Chicano tradition vis-a-vis folk health beliefs and practices of the family. The concept of folk healers or "curanderos" is an important one to bear in mind in the treatment of Chicano families. It is common and culturally beneficial for the therapist, whether psychiatrist or paraprofessional, to be called or perceived as a "curandero."

In a fascinating unpublished paper by one of our Chicano counselors (Atencio 1976), the idea of a "mi hijito" syndrome is being developed. According to the author, the "mi hijito" (literally,"my little son") syndrome describes a pathological relationship between mother and son. The mother's overprotective expression of love and tenderness, which is appropriate, perhaps, in childhood, becomes in adulthood a "destructive bonding relationship, so strong that mother cannot or will not recognize any wrongs or faults with her 'mi hijito' or his blatantly deviant behavior" (p.4).

The syndrome seems to me to have had its genesis in the mother's

[1]From James Jaramillo, "Chicano Traditions" (Unpublished. Albuquerque. New Mex.: Bernalillo County Mental Health/Mental Retardation Center, 1978) p. 3, by permission of the author.

response to the traditional powerful father Jaramillo speaks about. The cultural battering the Chicano family has gone through has proved fertile soil for its development.

> If not placed in context of a family dynamic, it winds up setting the therapist up as a lever to be used by the mother . . . the son sees the therapist as trying to change the status quo and not his mother (Atencio 1976, p. 2).

The difficulty encountered in family therapy, then, is in the therapist's efforts to get the family to shift into different roles that are more productive, yet acceptable within the cultural values of the Mexican-American family.

The Mexican-American family in the 1970s has a complex network involving an array of people. A typical family coming into therapy includes the powerful father, "somewhat aloof and distant," who himself was probably a product of the "mi hijito" syndrome; an infantalizing, guilt-provoking mother; a daughter caught up in the "movimento de la mujer Chicana"; and a son—perhaps the identified patient—who is narcissistically abusing drugs, going to school when he wants to, and is petulantly angry about the inconvenience of therapy. In addition, the therapist must be aware of the extended family or support system existent in the family. This will include "padrinos" (godparents), "compadres" (coparents, usually old family friends), "abuelos" (grandparents), and a string of cousins, aunts, and uncles second or third removed but still part of the support system. Another quite important member of the support system may often be the local or neighborhood "patron" who may or may not be a "compadre" of the family. The "patron" is the fixer, the person who gets things done via his more influential support system.

To complicate matters further, the chances are high that the drug abuser is buying or getting his drugs free from an old neighborhood friend whose family and support system parallels that of the patient. It is not uncommon for staff of our drug abuse treatment program to encounter such intermingling, and the untangling of this web is a credit to our sensitive and knowledgeable counselors.

STRATEGIES IN FAMILY THERAPY

Because of the cultural differences of the Mexican-American family, it is most important for the therapist to be specially skilled, and flexible enough to meet the needs of the family. Although it is not mandatory that the therapist be Hispanic, a cultural sensitivity is necessary. Home visits or family sessions away from the office are quite beneficial and common. The family's initial aloof respect for the therapist, with some suspiciousness, will often turn into a dependency, complete with

unannounced visits to the therapist and midnight telephone calls. The message from the Chicano family is clear, "You wanted in. We have let you in, and now you are part of our extended family." Again, sensitive case management is vital to the success of therapy.

The first time the therapist meets with the family is crucial. It is at this point that the therapist must begin to develop a rapport with the family. It is important, especially with Mexican-American families, that clear, structured goals be arrived at during this first session and a reasonable time limit set for achievement of those goals. This structuring is important because the experience of most poverty level Chicanos with agencies has been one of dealing with vague, amorphous organizations run by minibureaucrats with mystifying power.

The following case study will serve to demonstrate techniques used at the initial family conference. The family is composed of Mr. P., a 58-year-old laborer; Mrs. P., 51 years old; Barbara, 17 years old; Carolyn, 19 years old; and Robert, 21 years old. Robert is the identified patient referred by the courts. He has been using barbiturates for 3 years. Prior to that he was a solvent abuser starting at age 14.

Therapist: Hi, just have a seat somewhere. Let's see. My name is Bob Campos, and you're . . .

Mr. P.: I am Mr. P., this is my wife, Dolores. Barbara, Carolyn, and Bobby.

Therapist: So, how can I help you? (No one answers.) Well maybe I can start. Robert was referred here by the Probation Office for therapy and . . .

Mrs. P.: And you asked us all to come.

Therapist: That's right. In my experiences I always feel that the whole family is hurting when one member is in trouble and so I . . .

Mrs. P.: That's right. That boy has always hurt us so much.

Mr. P.: We have done the best we can. The girls always done good. "Que no hija?" ("Isn't that so, daughter?")

Therapist: . . . and so I like to at least meet all the family so we can decide what we want to do. Let's see, Mr. and Mrs. P., as you know I speak Spanish so we can talk both that and English. But you will have to excuse my "mochos" (literally chopped grammar). (The family laughs, begins to relax.) Robert, can you tell us what's been happening?

Robert: Oh, I got picked up for driving under the influence of downers . . . (he reports his drug history).

Mr. P.: "Es una verguensa." ("It is an embarrassment.")

Mrs. P.: "Hay que mi hijo" ("Oh my son.") He can't help it. Something's wrong with him.

Barbara: Mom, he's just lazy. You are always making excuses for him.

Therapist: Okay, we have three different ways of looking at Robert. Mr. P. is embarrassed for the family; Barbara is mad at him. Carolyn, you look bored by the whole thing and Mrs. P. has mixed feelings, mixed messages. Awhile ago you said he hurt

you, then you said he couldn't help himself, like he is an infant and at the same time you really look mad . . . and Mr. P. . . .

Mrs. P.: That's right. I don't know what to feel. He confuses me a lot.

Therapist: . . . Mr. P., when you say "una verguensa" is that for me? Do you feel that embarrassment because of me?

Mr. P.: Yes. I know your daddy and I know you come from a good family "y quisas piensas que nosotros son terrible" ("and you must think we are terrible") . . .

Therapist: Oh, now I remember . . . (There is a brief discussion regarding confidentiality, the option of a referral to another therapist. Mr. P., however, makes the decision for the family to remain with the therapist. This is coupled by a final word of confidence from him regarding the therapist and the therapist's "honor.").

Therapist: Okay Robert, let's get back to you and—uh—how the family sees you. The thing that's really hitting me is how much power you have . . . how much influence you have with the family—uh— . . .

Robert: Power, (laughs) what do you mean? I ain't got no power.

Therapist: . . . because you are the center of attraction.

Carolyn: Come on, Bobby, he's right. Mama's always rescuing you and takes care of her "pobre hijito" ("poor little boy").

Mrs. P.: (Laughs) . . . but what can I do, he has always been such a bad boy.

Barbara: Damn, I won't raise my kids that way—remember when . . .

Mr. P.: Barbara, "Quidado con tu lengua." ("Watch your tongue.")

Barbara: . . . they threw him out of school and you got mad at the teachers?

Robert: (To therapist) Hey man, you think I got power?

Therapist: Yeah man, I think you got power. We are seeing it right now and—uh—the other members of your family are really into taking the heat off you. You don't even have to talk or—uh—hassle because they do it for you. The thing that's sad—uh—tragic is that you could use that personal power—all that energy to get wasted—you could use it in a positive way. Like your father . . .

Robert: Yeah, maybe you're right. My dad is really macho. I really feel bad when I hurt my mom. (Mrs. P. begins to cry and successfully pulls attention away from Robert.)

Therapist: Well, that's what we are here to talk about. Let me see if we can make some ground rules. The way I work is that I want to have some very specific goals . . . things that we can all work towards. The other thing is that I want to see you people for six to eight sessions. And then we can evaluate what we have done and negotiate for another six to eight sessions.

(There is animated discussion on the goals by all the members of the family. The therapist helps in setting realistic goals for the six to eight sessions. The goals are simple: (1) Barbara and Carolyn will keep a log of when Mrs. P. rescues Robert; (2) Mr. P. will have the final say in any controversy; (3) Robert will try to stay "clean" and undergo weekly random urine tests.)

Therapist: There is one more thing I want to say. And it's really important to me and to what we do. I'm not the expert. You are the experts. Robert, you know more about yourself than anyone else does because you have been in your skin for 21 years. The same goes for your dad and mom and your sisters. And Mr. and Mrs. P.,

you are the experts on your own family. Because you have lived in it and formed it all these years. So, I'm not the expert. If anyone gets this family running again, it's you and your wife. All I can do is listen and suggest things and point things out.

Several important issues have occurred in that initial session that will set the stage for further intervention in the family. The interaction of the mother and son is now out in the open to be discussed and, hopefully, modified. This should (and did) happen without anyone losing face or "sin verguensa" ("without shame/embarrassment"). At no time was the father's position of power and influence threatened, but rather that position was reinforced. The importance of the sanctity, the wholeness of the family was acknowledged and also reinforced. Most importantly, the family and individual members of that family were in effect invited (and accepted) to join the "treatment team," thus taking ownership of and responsibility for the problem. The therapist remained in a position to move in and out of the family and demystified his role, thus making him more acceptable to that system.

Further sessions should be consistent with the ground rules developed in the first session. It is appropriate to bring in other members of the extended family only after asking permission and giving a rationale to the family for that action. It is also very important that the therapist be able to differentiate manipulation from traditional courtesy on the family's part. When making home visits or conducting therapy at the home, the phrase "mi casa es su casa" (my home is your home) is not mere rhetoric. The therapist should be open to informally sitting around drinking coffee or perhaps having supper with the family.

The question of conducting sessions in Spanish is an intriguing one. I do not feel it is a requirement that Spanish-speaking families deal only with Spanish-speaking therapists, although admittedly it is an advantage. There have been times when having Spanish-speaking clients rephrase or express an emotionally laden message in English (or vice versa) produces a totally different slant that the therapist can use therapeutically.

I have presented some ideas in the use of family therapy with the families of Mexican-American drug abusers, and I hope questions have been raised that will stimulate more interest in this modality. It is important to share such questions with other workers who have similar concerns about "la familia Chicano."

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5. Treating Adolescent Drug Abuse as a Symptom of Dysfunction in the Family

Nicholes Weingarten, M.S.W.

Fifteen-year-old Albert was brought into treatment by his parents, Barry and Connie, because he was using drugs, was not functioning in school, and was a behavior problem at home. After some exploration it became evident that Connie was an alcoholic who disappeared from home for days at a time. Barry portrayed himself as a hard-working construction foreman who was fed up with Connie's behavior but felt helpless to do anything about it. There was one other child in the family, 18-year-old Doris, who was the "good girl."

In the first interview, after determining how Albert's behavior affected everybody and how they all saw his problem, the therapist refocused on the parents' marital difficulties. The therapist determined that they had had marital problems since the first year of marriage. As he began to get mother's family history, she began to tell about her childhood and her losses. Upon hearing this, Albert's sullen expression changed to open-mouthed fascination, and he even began to ask questions about what his mother was telling us. After 4 weeks of exploring the parents' history and marriage, the therapist asked how Albert was doing and learned that there had been no behavior problems or obvious drug abuse since the family had been in treatment.

In this case the therapist moved the focus off the identified patient and onto the marital dyad early in the treatment. Albert had been appointed the "symptom carrier" in the family so that his parents could focus their arguments and concerns on him, thereby avoiding having

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to deal with their own problems and relationship. In this case, the therapist moved off the symptom quickly; in other cases more time may be required.

There is no simple answer to why an adolescent "chooses" drug abuse instead of displaying other symptoms. What is clear is that drug abuse in adolescence that comes to the attention of treatment agencies or the criminal justice system always reflects some dysfunction in the family. Symptomatic adolescents can be viewed in a variety of ways. One view is that they are serving to maintain their parents' marriage. Parents' mutual concern about the child may take the form of talking to each other about what to do, or they may argue with each other about whose fault it is. In many families this may be the only time the parents talk to each other meaningfully. In other families where the marriage has broken down completely the drug-taking issue may be the only thing keeping the parents together. I have also seen cases where parents who have been separated or divorced stay in touch with each other only because of a drug-abusing child. In this kind of situation I would view the symptomatic child as attempting to help the parents, and in the beginning of treatment I would label this behavior as an attempt to save the parents' marriage. In some cases when I have told children they are no longer responsible for saving their parents, they have visibly sighed with relief or burst into tears.

Another view of symptomatic adolescents is that they are serving as a vehicle to release long-suppressed rage and anger in the family. The B. family consisted of mother, father, 21-year-old daughter, and the 16-year-old son, who had been abusing PCP. The family was furious with this boy because of the trouble his drug abuse was causing them. On one occasion when the boy had come home intoxicated, father got into a physical fight with him and mother joined in to help out father. In the therapy sessions everyone was verbally abusive to the boy. While exploring the family's history I learned that mother had colitis and father had ulcers. The family members explained that they had never become angry with each other until this boy started acting up. They felt that they had been well adjusted, and that it was wrong to show anger because it could hurt people's feelings. They also associated expressing anger with either being crazy or with violent destruction. In fact, they were angry at this boy because he made them express their anger. After extensive exploration father began to talk about his frustrations at work, where he was constantly belittled and humiliated by others. Mother talked about her long-suppressed hostilities toward her husband and her mother because of their constant demands on her. Previously she had been able to express such feelings only in a passive-aggressive manner. Daughter could not tolerate the anger that was coming out and left treatment after a few sessions.

The parents' fear of separation from their child or children has been viewed as another important dynamic in adolescent drug abuse. In families in which this occurs the symptom surfaces at a time when a parent (often the mother) is threatened with the real or symbolic loss of a child. This can be seen when either the oldest or youngest child is ready to leave the home, or when the symptomatic child reaches adolescence and is beginning to look for some independence. The parents' fear of separation from the child may be seen as relating to their inability to separate from their own parents. Having never resolved this, the loss of the child is as emotionally laden as if the parent were being abandoned by his or her own parent. The adolescent, whose normal conflicts around autonomy are difficult enough to deal with, becomes overwhelmed by the additional pulls from the parents and turns to drug abuse. This not only relieves the painful conflict but also in itself gives the impression of autonomy.

A variation on this theme occurs when there is a blurring of generational boundaries. This factor, which is common in families of drug abusers, can be seen in the extremely close relationships that exist between mothers and male drug abusers or fathers and female drug abusers. In these relationships, the parent and child often behave as if they were the marital dyad, with the other parent and other children excluded from the relationship. At times this is immediately obvious in the session. For example, when parent and child sit next to each other, hold hands, talk to each other, or wink and smile at each other when others are talking. Sometimes it is less obvious and can be seen in the fighting (competition) between child and parent of the same sex, or the isolation of the same-sex parent, or in observing which parent keeps coming to the rescue of the child when he gets into trouble. Close relationships such as these that are less obvious to the outsider may require painstaking and delicate exploration, because the family is invested in maintaining what they feel is a vital balance.

Yet another theme I have observed has to do with the vicarious, unconscious gratification the parents get from the adolescent's behavior. This can sometimes be seen in the parents' obsessive need to know about the drugs the child uses. Their constant questioning of the child and other sources about dosages, dealers, and drug reactions can be seen by an outsider to amount to a fascination with the "drug scene." Although the parents may express horror and anger at the child's illegal and antisocial activity, they will often make the child recount every detail in the therapy session, and even fill in the details the child forgot. Where this exists, there may also be a lack of consistent limit-setting by the parents, as well as a lack of structure in the family. The child is often confused about what is appropriate and inappropriate behavior.

Fourteen-year-old Donald was referred by his school because he was often aggressive and violent in school. He had been seen intoxicated on many occasions and was known to be especially hostile to female staff and students. In the initial family therapy session father was unusually angry about Donald's aggressive behavior. He did not understand it and kept referring to aggression as alien to their family life. Mother sat quietly fuming during all this. After a few sessions Donald pointed out that his behavior was not much different from when father dumped a bottle of ketchup on mother during an argument at dinner. Mother, at this point, reminded father of his "temper tantrums" when he would literally tear up the house. In another session mother smilingly complained about Donald's killing birds with his BB gun. Donald pointed out that it was not different from when he and father went fishing and father would shoot seagulls. Father would also kill the fish he caught by shooting them through the mouth. Father's constant denial of his anger and mother's quiet rage were confusing enough for this boy. In addition, neither parent could ever talk about Donald's misbehavior without smiling or laughing.

Another way of looking at the adolescent drug abuser is that he is acting out something in the family which is a repetition of intergenerational issues that may have been handed down for several generations. These repetition themes may take many forms and can be associated with any of the previously mentioned themes found in these families.

One other common repetition theme is death and loss. The drug abuser is always flirting with death. The parents, in turn, have a constant fear of the child's death. When the parents' histories are explored we find that there can exist two kinds of losses in their lives. One kind occurs when the parent has lost his or her parent through death, divorce, or desertion, and this loss was not adequately mourned and resolved. The other occurs if the parent has had a significant loss either just prior to the drug abuser's birth or when the drug abuser was very young. In these cases, the parents were too involved in their own grief and were not able to nurture the child. The child in turn feels this emotional deprivation as loss of his parent. Drug-abusing children are not only expressing their deprivation but also are helping out their parents by their risk taking and deadly behavior. This behavior stimulates the parents to grieve for the child as well as work through the other losses the parents suffered.

Another repetition that is commonly found in the families of origin of drug abusers is some form of substance abuse. This can go back several generations where parents, grandparents, and great grandparents have been using drugs or alcohol to excess.

One of the key conceptual tools in treating families of adolescent drug abusers is to be able to see the adolescent as trying to help his

family in some way. Sixteen-year-old Frank was brought in to therapy by his parents because he had been arrested for possession of drugs. He had been in trouble for the past 5 years. His behavior appeared to be precipitated by his father's heart attack which left father functioning like an invalid. The family also included a 10-year-old boy and an 18-year-old girl; all came in for family therapy.

After the first few sessions that focused on getting a family history, the parents began questioning why we were not focusing on Frank. We reclarified our approach for several sessions while delicately exploring the family interactions. When we started to look at the parents' relationship with each other, mother became furious and refocused on Frank. Frank had been refusing to talk since the therapy began, so focusing on him meant that everyone would complain about how bad he was. When we explored for which person Frank was most like in the family, it turned out to be mother's brother whom she "adored." She did complain that her brother had given up a good wife and a lucrative medical practice to become a "hippie artist" at age 35. Frank's father worked part-time "under the table" while claiming he was still under doctor's orders not to work.

After 5 weeks of being straight and behaving, Frank got arrested again. This time the police had clearly made a mistake and dropped the charges. However, this was enough for the parents to insist that the treatment team needed to focus on Frank rather than on their relationship. It had become clear in the previous session that the only things holding the marriage together were the children and the parents' fear of shaming the family. Once again we tried to look at the family system and once again mother objected. Several days later Frank came home intoxicated. His parents rushed him to an emergency room and then took him to family court to have him placed in a residential treatment program.

By getting into trouble Frank was able to help the family avoid dealing with the many critical issues in their lives. As the treatment began to strip away the thin defenses and expose the emotionally charged issues, Frank escalated his acting out to divert the therapy. When this still did not work, the parents began to dilute the treatment by going to another agency for help, although they insisted on continuing their therapy with us while waiting for Frank to be placed.

In this kind of family it would have been easy to focus only on the child, or even to see the child individually. Many good therapists have chosen this approach. If these therapists succeed, however, in changing the child's behavior, our experience has shown that another family member will pick up the symptom. This is usually another child. There is another risk in working with the symptomatic adolescent individually. When we work with individuals we tend to see their world through their eyes. After a while we begin to believe that mother or

father really caused the problem. In doing this we miss the fact that the whole family is suffering and that some family members may be in even greater pain than the symptomatic child. By working with the family system we not only help the symptom carrier but also free up his family of origin, and in the long run prevent the repetition of family themes in the coming generations.

It is important to mention that these themes and issues that are common to families of drug abusers can be found in other families as well. The one difference is that when these issues exist in families in which there is drug abuse, they tend to be much more intense, more explosive, and to produce more crises than in other families. Because of this intensity family members are more prone to physical and emotional illness and violent behavior. I would suggest that unless the whole family is treated, the work with the symptomatic adolescent will be more difficult and generally less successful. However, if the adolescent drug abuser is viewed as the one who is trying to help his family, the family can then use him as the ticket of admission to treatment and change.

6. Why Family Therapy for Drug Abuse? From the Clinical Perspective

Donald I. Davis, M.D.

Research literature suggests that, however unwelcome, drug-abusing behavior can become an integral part of one's family interaction in ways that have major implications for the treatment of abuse (Klagsbrun and Davis, 1977). A survey of U.S. programs that treat substance abusers has led to the conclusion that a great many therapists in the field conjecture that more and better family interventions would offer the best hope for improved treatment success (Coleman and Davis 1978). Indeed, compelling arguments have been made that there is now ample evidence that some form of family intervention should always be attempted in the treatment of the substance abuser (Stanton et al. 1978; Paolino and McCrady 1977; Davis, in press). Yet there remains a lack of descriptive literature to illustrate some of the more subtle but crucial ways in which drug abuse and relationships become intertwined. The clinical material that follows is included in an attempt to capture for the reader some of the relationship issues seen in substance abuse that make family therapy seem uniquely applicable.

Four areas will be addressed: (1) the role of drug use in the marital relationship; (2) the effect of abuse on the next generation; (3) the importance of an effective family response for the drug-abusing youth; and (4) the family as a source of resistance or aid in the treatment of the substance abuser. Three case studies are presented to illustrate these points.

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CASE 1: SEDATIVE HYPNOTIC USE AND A MARITAL IMPASSE

The couple had been married about 3 years. Husband had one school-age child by a previous marriage who visited frequently but did not live with them. She had no children and had not been previously married. Both worked full-time out of the home at equal levels of responsibility and pay. She was using Valium several times a day and had been for about 4 years prior to the couple's therapy. It had initially relieved her symptoms of anxiety, cramps, diarrhea, and weight loss. Whenever she had stopped taking it, her symptoms soon returned worse than ever. In her individual psychotherapy she had begun to talk about wanting more happiness from her marriage, and she and her husband had accepted a referral from her therapist for couples therapy. Drug abuse had not been identified as a problem for either spouse.

Meeting as a couple with a therapist for the first time, neither husband nor wife could identify a specific problem other than the wife's physiological symptoms and anxiety, which they felt were now under adequate control. Yet each agreed that without greater happiness together, their marriage was untenable. By pursuing questions about their relationship and what each might like to see different in it, the therapist learned that husband would like to have more companionship from his wife in the evenings after work. Sex was fine, but she went to bed by about 9:00 p.m., which, with their busy schedules, left little time to talk. With the advantage over individual therapy of having both parties to a conflict present, it was possible to reach an agreement that she would stay up weeknights until at least 11:00 p.m., provided he would not turn on the television unless she requested a particular program. They tried to carry out the agreement but initially could not. She found she was unable to stay up as promised and still use her Valium. This frightened her, as did the discomfort she experienced when she proceeded to abstain.

It is worth noting before proceeding that her individual therapist had not identified her use of the sedative hypnotic drug as a problem because the problem was manifest in aspects of her marital relationship inaccessible to him. As clinicians so often find, it may be only through in vivo work on the details of relatively trivial conflicts that we can effectively find and then convince the substance abuser that there is a drug abuse problem.

In this case, documenting the problem within the context of the relationship also provided a treatment advantage. At least one major function of drug use for this couple soon became apparent. With their busy schedules and her early fatigue, they simply were unable to discuss

certain fundamental differences between them that had always been present but never resolved. For example, he did not want more children, while she considered having children as essential for her fulfillment in life. Deep down, each had always known the other's wish but had counted on his or her changing. As the years went by they were no closer to resolving their differences. In fact, because of the drug use, they had not even developed a mechanism for seeing how far they could go in resolving differences. Individual work, even the effective work she had experienced, had brought the couple no closer to learning how to solve their mutual conflicts. Had she stopped her drug use without her husband's working with her in a mutual effort to adjust to the change, the pressures to resume would have been enormous. Actually, she had at times questioned if she had a dependency on the drug and had cut down, only to convince herself and her doctors, and be convinced by her husband, that the return of her symptoms necessitated the perpetual use of the drug.

Effective treatment for this couple necessitated the identification and treatment of her sedative dependency. Having the couple working together in treatment prevented the husband's resistance to her giving up the drug. Further, it allowed for securing his active support in the difficult first few weeks that she abstained. Subsequently, with drug dependency out of the picture, the marital impasse was addressed and resolved.

CASE 2: AN EFFECT OF ABUSE ON THE NEXT GENERATION

The following case illustrates a common finding in the family of a substance abuser who does not accept the diagnosis. In this case, father is an alcoholic and older son is underachieving in his school work. The association between father's misuse and teenage son's behavioral problem is subtle, but I believe an argument can and should be made that it is a crucial factor to be dealt with if the son is to be helped. As will be shown, working with the son in the context of the family also becomes a critical factor in the treatment of his alcoholic father.

Father was referred by his family physician for psychiatric help because of his apparent depression, which was manifested chiefly by weight loss, lack of interest in nonwork activities, sleeping long hours, and irritability. When he and his wife were seen together, it became clear that he had been a chronic excessive drinker for many years. It was also clear that his wife had long since concluded that he drank too much, but she had not felt there was anything she could do about

it. She had, however, taken over responsibility for all aspects of home and child care. Both felt that their two teenage sons had largely been spared any consequences of father's problems, although they acknowledged that the school felt their older son's academic performance was consistently at a level well below his ability. Younger son, for all his talents, was painfully shy.

The parents were persuaded to bring both of their sons for family sessions. Meeting with the whole family, the therapist learned of the many ways in which alcohol was a factor in problems between different members of the family. Most noticeably, the boys indicated that they steered clear of their father whenever he was drinking lest they incur what they perceived as his unjust wrath. Since he drank nightly, that meant they rarely brought their school work questions to him and usually ignored his commands rather than question or challenge him directly.

The family was told that alcoholism was clearly a problem for all of them. Mother and sons were admonished for not acting on their beliefs since they knew of the alcoholism and had taken no steps to seek help. Mother began attending Al-Anon and sons attended Alateen. Father adamantly refused to go to AA. He also refused to stop drinking. Since he did have signs of clinical depression, he could agree to reduce his drinking substantially as part of the treatment of his depression. He was told that it was unsafe to give him antidepressants with his current drinking habits because of the potential harmful interactions of the drugs. Further, he was advised that it would be impossible to tell whether his depression required medical intervention at all until he had an extended period without heavy drinking.

It was agreed then that he would reduce his daily intake at a pace at which he knew he could succeed. Over a period of weeks he reduced his intake to not more than two drinks per day on all but rare occasions. He maintained this level of drinking for several weeks, during which time his depression largely disappeared. Wife and sons remained skeptical of his success since he was still drinking something, and he resented their lack of support. He became a more active participant in therapy sessions and in home discussions as well, and the focus in treatment was then shifted from his drinking to school or social problems the boys were experiencing. Steps were taken to help mother and father work together more effectively in supporting their sons' efforts, and in setting expectations for school performance.

After a while it became apparent that the shy son had blossomed socially but that the underachieving son continued simply not to do some of his homework. A parallel was drawn between son's behavior and that of his father. Son admitted that he felt his lying about whether he had completed his homework was no different from other lying that went on in the family. He included both father's lying about whether he

was truly an alcoholic and needed to stop drinking altogether, and mother's lying when she covered for father in many subtle ways. The family was at a stalemate. This stalemate persisted until finally son was helped to express his concerns for father and offer to do his very best in school the coming year provided father would accept his alcoholism and show it by stopping drinking altogether.

For the purpose of this paper it should be emphasized that in this case previous individual therapists had not been able to get beyond the primacy of depressive symptoms with this father. Work with the family did seem to have a significant benefit with regard to initiating favorable change in husband's drinking behavior. Wife's attendance at Al-Anon was probably the major outcome of couples work that allowed treatment of the alcohol problem to progress beyond what individual work had accomplished. Yet it was only through therapy with the whole family that sufficient leverage could be brought to bear for the achievement of abstinence. Simultaneously, through family therapy a link could be clearly established between parental alcoholism and a behavioral disturbance in an adolescent child; and a solution to the child's problem could be achieved as well.

Two clinical illustrations have been presented in which an adult was the substance abuser. The first case highlighted how sedative use can come to serve a function in a couple's relationship. It also illustrated the value of couples therapy in the identification of a drug problem and in overcoming resistance within the marital relationship to a change in the drug-using behavior. The second case provided an example of the role of family therapy in secondary prevention of behavioral disorders in offspring of substance abusers. This case also described how family therapy, including children as well as the spouse, can be used in the treatment of an alcoholic parent.

What role does the family play in the therapy when a teenager is the drug abuser? In our alcoholic parent example, the teenager might well have been a drug abuser. Such situations are common in clinical practice. Hopefully, that example will already have suggested the importance of family therapy for the teenage drug abuser when a parent is a substance abuser. Even when there is no other drug abuser in the family, however, there are often compelling reasons for selecting a family approach to the treatment of an abusing child.

CASE 3: WORKING WITH A DRUG-ABUSING SON AND HIS MOTHER

Only a brief clinical example of a teenage drug abuser will be offered here. It involves a 15-year-old boy who was using marijuana

several times daily and experimenting with a wide variety of other psychoactive drugs. He had also attended high school irregularly for several months. He was affable and intelligent. He lived with his mother and 21-year-old brother, who had himself been a high school dropout. Mother was divorced and had a good job. The two boys occasionally did part-time manual work. Father had not had contact with his sons for many years. Mother had always perceived both boys as a delight to be with and enjoyed having them around. She wanted them to be happy in their life pursuits and unconstrained by conventional requirements. As long as they applied themselves to whatever they chose to do and were self-sufficient and satisfied, she would be pleased.

She did resent their lack of help with household chores and in earning money. While she occasionally spoke up about these matters, it was usually in the form of an emotional blowup after a lengthy accumulation of grievances. The sequelae of these explosions were a mixture of apologies and expressions of hurt from the boys, and guilt and backing off on mother's part. Behavior did not change.

In the course of therapy mother came to acknowledge that she had conflicting goals and expectations for her sons and that these were reflected in her inability to set firm limits on her younger son's school, home, and drug-using behavior. She wanted her sons to be free of restrictions, as she felt she had not been in her youth. She wanted them to choose pursuits based on personal preferences. Yet she secretly hoped that their choices would be in the professions that required discipline and extensive preparation. Hence, she gave them as much latitude as possible in growing up, only to explode from time to time when the frustration because of their selfishness and academic failure set in.

With reframing, the family was helped to see that the younger son's behavior was actually his way of showing that he identified with and admired his mother, and was trying to behave in a way he thought she wanted him to act. She had shared with him, from time to time, her own disdain for school and other authorities. He got the message, and his failure to show up at school was largely a reflection of his wish to comply with her expectations for him. Mother was guided into taking increasingly firm positions on a number of issues, such as household chores and drug use in the home. Seeing the effectiveness of her efforts, she had to admit that she and her son were indeed in a cooperative venture and that it was within her power to change the course of their behavior.

A decrease in drug-using behavior followed mother's first firm, consistent laying down of rules for drug using and other behaviors in and around the house. These were made conditions of staying at home.

They were tested, but were generally accepted whenever mother stood firm without overreacting.

The message in this case and others like it seems to be that, to the extent that loving parents are ineffectual in limiting drug-abusing behavior, the behavior is perpetuated. It seems that by easing the consequences of drug-abusing behavior, other family members prolong the time it takes for the abusing teenager to realize the destructiveness of the habit. By working with the family, a skilled family therapist has the added leverage to effect change that comes with influence over the relationship factors that help sustain drug-abusing behavior.

As was said at the outset, a strong case has been made by several authors for use of family therapy in the treatment of all sorts of substance abuse. The more pragmatic arguments have included that most substance abusers are still very much involved with their families, that increasing numbers of therapists in drug treatment programs want to use more family techniques, and that treatment outcome studies for family and marital approaches in the field are encouraging (Stanton et al. 1978; Coleman and Davis 1978; Paolino and McCrady 1977; Davis, in press). A foundation also has been laid through clinical research for conceptualizing approaches to treatment of substance-abusing behavior in relationship terms. There are recent reviews of the considerable and growing literature that document this point (Harbin and Maziar 1975; Klagsbrun and Davis 1977).

In this paper an attempt has been made to bring to light through clinical illustration a few of the more subtle but quite poignant interpersonal issues that often go unattended in the traditional, nonfamily approaches to the treatment of substance abuse. There are, of course, many more interpersonal factors that can arise than have been dealt with here. When members in families are abusing a drug, marriages do not flourish, parenting suffers, offspring are at high risk for drug-related problems, and the family as a whole has a serious problem in its relationship with outside society. When a drug abuser abstains through treatment, family members may serve as an unwitting source of pressure to return to drug use if they themselves are not included in the treatment and helped to understand and adjust to the changes brought by the abuser's abstinence.

Thus, there are many compelling reasons for turning to family therapy in the search for better intervention techniques for dealing with the problems of drug abuse. The practical treatment literature in this field has been modest, but that is changing rapidly. Stanton has recently provided us with a comprehensive bibliography that includes virtually all the treatment related articles in the field through 1978 (Stanton 1978). An in-depth study of the treatment literature he listed would be rewarding. It would also show, however, that much more re-

mains to be said about what to expect and how to intervene with substance abusers and their families. Only more clinical work and research with family therapy for substance abuse will allow us to fill in these gaps in our knowledge.

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7. The Strata Beneath the Presenting Problem

Florence W. Kaslow, Ph.D.

Just as all that glitters is not gold, so too the symptom or conflict that is first portrayed to the therapist is not usually the real substance of the pathology or dysfunction. Often it takes weeks to months to cut through the shiny or tough surface, the patina on the alloy, before one reaches the interior and becomes more certain about the elements that combine to form the complex web of personality. Penetrating through the defensive armoring of patients (Reich 1928) requires skill, tact, and insight as well as the ability to form a solid therapeutic alliance. It is frequently necessary to strip away, gradually, the outer layers of superficial problems that are the external manifestations of deep-rooted conflicts, being certain to replace such defenses as projection, rationalization, denial, negation, displacement, and repression with more effective coping mechanisms by strengthening a person's ego, sense of self-esteem, and reality-testing ability. If the therapist moves too rapidly to clarify, interpret, or develop insight, the patient may be overwhelmed by more ego-dystonic data than he or she is able to emotionally comprehend and accept. The resulting anxiety and confusion can exacerbate the depression or other symptomatology.

If things are not always what they seem, and if effective treatment is predicated on an accurate differential, dynamic, diagnostic understanding of the patients one is seeing, and of the nature of the relationship and interraction between them (in marital and family therapy), (Martin 1976), then arriving at a broad enough formulation to proceed to make therapeutic interventions requires a picture of both intrapsychic and interpersonal factors. This paper is written using an eclectic

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approach strongly rooted in psychoanalytic (Freud 1933) and humanistic (Maslow 1954) theory and technique. Since what is being sought here goes well beyond symptom relief and encompasses personality restructuring and often a different lifestyle, narrow band behavior modification approaches (Skinner 1971) are deemed not to be adequate. However, a broad spectrum behavioral strategy emanating from Lazarus' multimodal approach (1976) might be feasible and compatible with the ideas expressed herein.

MARITAL CONFLICT AS REASON FOR ENTERING THERAPY

The following case is taken from the author's private practice.[1] The patients were white, lived in a suburban, upper middle-class neighborhood, were involved in community activities and were perceived by relatives and friends as solid, relatively stable, respectable, and contributing members of society. They would not have been perceived as deviant, particularly nonconforming, or unable to function in accordance with conventional standards of behavior and morality. This case was selected as prototypical of many where marital or family conflict, school or work adjustment difficulties, interpersonal relationship problems, and/or discontent with one's life are the factors that are purported to motivate a person to seek treatment. Yet the therapist often finds that even in the midrange population (Lewis et al. 1976) many private practitioners and suburban agencies serve, a number of our patients are substance abusers, though often of the more covert variety. They do not present as such and superficially appear quite different from the person designated an addict or alcoholic, but more careful analysis reveals similar dynamics and difficulties.

THE CASE OF B.J.

Barbara Jo called, ostensibly to request marital therapy. She was soft-spoken, pleasant, and very sad. Her marriage of 6 years was fraught with conflict, emanating primarily from her inability to be the all-giving wife her husband wanted, and vice versa.

A joint interview was scheduled for Barbara Jo and her husband, Ted. They were an attractive, tall couple. She was somewhat pretty and presented as a "goodie, goodie," quite sweet, innocent, and

[1]Details are sufficiently changed to protect the person's identity.

slightly dowdy in baggy dungarees and loose-fitting overblouse. She wore no makeup, and her long, dirty-blonde hair hung in a natural, unsophisticated style. Although B.J. was 26, she appeared and related more like an inexperienced, naive girl of 18. By contrast, Ted was well-groomed and tailored, much neater, with dark, handsome looks highlighted by brooding eyes. He seemed unaware of his fine physical attributes and was frightened by the idea that his wife was considering a temporary separation as she needed "space" and was no longer sure she wanted to spend the rest of her life married to and dependent upon him.

Like many individuals who call a therapist to arrange for marital therapy, B.J. had already decided she wanted to separate. For such people therapy constitutes a last attempt to prove they "really tried to make a go of it" and serves to alleviate some of the guilt about breaking up the marriage.

B.J. had already made arrangements to move in with a female colleague with whom she worked. In the third therapy hour she articulated to her husband and to me that she had to move out, as she felt smothered and did not know who she was or what she wanted out of life. The decision to leave was nonnegotiable and marked for her one of the rare times she had independently made a major choice for herself.

Ted remained in individual treatment for about 6 weeks, trying to understand where he had failed and working on his fury at B.J., and on a deeper level at his mother, who, in her nongiving way, had also been unavailable to him emotionally. He then decided to relocate, hoping that by distancing himself, he could lessen the pain.

B.J. remained in therapy for a year and a half. During her weekly psychoanalytically oriented sessions, she revealed that she had been adopted during infancy, and though her adoptive parents and their relatives were "wonderful" to her, she never felt she belonged. The adoption was rarely discussed. During her childhood she lived with her parents, a grandmother, and maiden aunt. When she was 16 her mother died and B.J.'s grief was extreme. The wreath she placed in her mother's casket was heart-shaped. She figuratively had buried her heart with her mother.

When she lost her (adoptive) mother her grief was compounded as her curiosity about her natural mother resurfaced. But no one was receptive to her desperate questions about her heritage; asking about her biological parents was tantamount to heresy, and so B.J. continued to smile sweetly, lest she offend and thereby eliminate any of the remaining people in her fragile family network.

Two years later her father remarried and moved west with his new wife, finally escaping from his ex-wife's ever present in-laws. B.J. felt

unwelcome by her stepmother, and when Ted, whom she had already begun dating, said she could move in with his family she hastily did so, embracing him, his parents, and siblings in her desperate quest for love and belonging. Her aunt was infuriated at B.J.'s "desertion," and when the grandmother died several years after B.J.'s mother's death, the aunt became very hostile and rejecting toward B.J.. Thus, when Ted completed college and asked B.J. to marry him, she willingly assented, hearing the promise of security and eternal love she longed for.

During the next 6 months of B.J.'s individual therapy we worked on themes of loss through desertion and death, grief and mourning, feeling worthy of being loved, trust and commitment. B.J. was dating and getting some satisfaction from one relationship in particular, with Steve. She often spent weekends with him and his friends, and commented that they were fun, although the group was a somewhat downtrodden one.

In February B.J. became noticeably depressed and some suicidal ideation was expressed. I picked up Valentine's Day as a crucial time for her; she seemed to experience an "anniversary day" reaction related to burying her (symbolic) heart with her mother, also feeling terribly alone and unloved on this lovers' holiday. Touching upon this sensitive nerve caused a panic reaction, and B.J.'s functioning began to deteriorate. At this point an antidepressant was prescribed and therapy sessions increased to twice a week to help her through the crisis period.

At her next session she was still in very low spirits, lacked animation, and was having difficulty sleeping and working. When queried about the medication, she indicated she had been unable to take it and looked sheepish. Then she reported that she had not wanted to tell me that the weekends with Steve were prolonged pot parties, that they often used cocaine and sometimes popped pills. Since her transference reactions to me included my being the "good nurturing mother," she had assumed that I, like her adoptive mother, would be unable to accept her drug involvement, and so she had purposely decided not to tell me. But she did know not to mix medication and the substances she was using, and now realized her therapy could not progress further if she withheld this vital information.

B.J.'s finally dealing with her drug (and alcohol) abuse became another therapeutic milestone. She was ready to confront herself more accurately and to trust the therapist sufficiently to be her "real" self, whatever that was. She recognized that she felt unable to get through the long weekends without the crutch of altering her consciousness by resorting to drugs. This had also been true during her marriage; when not under the influence of some substance, sex with Ted had not

been very good (partly because she was passive-dependent, inhibited, and did not know how to find pleasure in sexuality). Thus, they resorted to pot-smoking so they could get high before having sex.

Further exploration using free association and some flashback approaches helped B.J. remember her mother's prolonged illness. Since she had had cancer, the dosages of painkillers were frequent and heavy. B.J. learned well that drugs provide escape from pain, and to the extent she identified with her mother and partially incorporated her after her death, the substance abuse represented both the identification with and being like her mother. It provided a continuing link to her beloved yet hated love object who had abandoned her. Since B.J. had been the major caretaker during her mother's last months, she felt that she had failed in not being able to save her life.

DISCUSSION

In the foregoing illustration we see the immature, depressed, dependent personality so frequently associated with the substance abuser. B.J. had an oral character disorder with marked depressive features. She continually felt emotionally deprived, longed for nurturance, and feared the repetitious abandonments. Coleman and Stanton (1978, p. 79) have pointed out that drug addiction has suicidal ramifications, as the individuals are participating in causing their own slow destruction, that death itself has special significance in the familial and personal history of substance abusers, and that the significance appears to arise from "unresolved and premature deaths experienced." Clearly, B.J. had experienced several premature and traumatic losses of important love objects, and when she entered therapy these were unmourned. Her continuing identity confusion stemmed in part from being adopted. She had an overwhelming sense of anger, grief, and guilt in relation to the loss of her natural parents, and adoptive mother, father, and grandmother. All these factors, combined with the lack of sustained and adequate nurturance, provided fertile soil for depression, suicidal thoughts, and substance abuse as a plea for attention, help, and gratification.

Treatment in the final stages included helping B.J. develop a better self-image, and to become engaged in social activities with peers not involved in the drug culture, as she decided she no longer wanted or needed to be programmed to self-destruct (the masochistic substructure was worked through). She also was enabled to complete the grief work by: 1) seeking to find out about her natural parents, her heritage, family health history, and why she had been given away; 2) reestablishing contact with her father and stepmother to indicate she

wanted a mutual affectionate relationship with them; and 3) visiting her mother's grave to really resolve the loss and separate from her dead mother (Williamson 1978, pp. 93-102).

By the time treatment was terminated B.J. had been away from drugs for 4 months, was jogging daily, eating a more nutritious diet, playing tennis, and thinking of returning to graduate school. The sweet, inhibited, sad facade was replaced by a more vibrant quality.

This case illustrates that some individuals who contact therapists about a variety of problems are either unaware of the extent of their involvement in drug and/or alcohol abuse or do not recognize it as both a symptom of their underlying difficulties and a way of coping with their pain, grief, anxiety, and uncertainty. It is advisable for therapists to explore what, if any, drugs or medications are being utilized, with what frequency and under what circumstances as they attempt to ascertain a clear picture of the patient's functioning, lifestyle, and social milieu. That is a vital piece of data in fashioning the jigsaw puzzle that comprises the interior and exterior life space of patients, without which therapists cannot help them move to a real integration of the self so that they are, in truth, what they seem to be, and the glow is a natural and not an artificially induced high.

Although initially in the case discussed two patients were seen conjointly and later B.J. was seen alone, *the assessment and interventions were based on a family systems perspective.* B.J. spent many hours reworking the unfinished business from the past regarding her unknown biological parents, her dead mother, and her estranged father. It appeared necessary to this therapist to handle this intergenerationally, even though her important others were not physically present. Only in unlocking the pain, grief, and love connected to her psychological family of origin could one understand, work through her many symptoms, and move beyond the polydrug use and her inability to build or sustain the level of intimacy a lasting marriage entails.

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8. Family Counseling for Low-Income Drug Abusers

Elisabeth J. Johnson, R.N.

The material contained in the following pages is drawn from experiences dating back to 1964 at the Drug Addiction Rehabilitation Center (DARC) in Boston. The descriptive narrative is from direct observation. As chief nurse of a residential therapeutic community located within a large mental hospital, I was involved in all aspects of the treatment program from admission to aftercare. The program included opiate and barbiturate withdrawal, daily encounter groups, individual counseling, vocation counseling, and couple and family therapy.

Our unit was originally established in the traditional medical model in which the patients were the passive recipients of medical, psychiatric, and nursing expertise liberally dispensed along with a hefty dose of advice on all aspects of the patient's life. In addition, nurses and doctors maintained appropriate professional distance from their deviant charges, which was reinforced by the wearing of uniforms and certain formalities of conduct. It should not be surprising that the early treatment efforts met with failure. The nurses and assistants were constantly plagued by forbidden behavior of the patients, including drug and alcohol smuggling, violence, and thievery.

Out of sheer self-protective necessity this drug unit evolved from a mockery of good treatment to a model therapeutic community in which patients became partners in the treatment process and planning. At first we thought that our problems were due to deficiencies in our ability to deliver good psychiatric treatment, but we eventually realized that it was not the skill that was lacking, but the model. The medical model was too rigid and did not allow for client contribution to the operation of the unit. Gradually we added more flexibility;

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clients increasingly assumed responsible roles within the organization. Undesirable behavior was reduced markedly after the change, probably because the new approach made the patients responsible for controlling their own behavior, which the staff had never been able to do.

Treatment included daily encounter groups that, using the reality therapy approach (Glasser 1965), focused on the here and now. This method was used instead of the psychoanalytic, which was favored in the rest of the hospital, because we found that the achievement of insight was not effective with our clients. In fact, they tended to use insight about early life traumas as a "cop out" for not gaining treatment success. Emphasis was placed on attitudinal and behavioral change. We encouraged participants to face feelings about difficult issues honestly, practice new methods of dealing with old conflicts, and learn new social skills. These activities fostered a climate of sharing and intimacy which the patients and staff very much enjoyed. This group cohesiveness was very hard for outsiders, even families, to penetrate. These dynamics, in fact, led eventually to the development of a family counseling component.[1]

Staff relations with families seemed to go through phases. Initial contacts were usually cordial and cooperative. Relatives expressed gratitude and relief for the fact that their drug-abusing child or spouse was receiving help. Not a few mentioned being able to sleep for the first time in months, not having to worry about receiving a call in the middle of the night heralding disaster. After the initial enthusiasm, a kind of disenchantment set in for many families as they encountered the frustration of seeing the patient develop new strengths and skills, yet remaining unready to return to the family to work on old conflicts there. Families often began to pressure the patient to assume more responsibility than he/she was ready for. In the most serious instances, the resident might resort to old patterns of dealing with stress, using drugs or alcohol. It was in order to ameliorate these situations that the drug unit began to offer family counseling.

FAMILY ISSUES AND DRUG ABUSE

As was noted earlier, DARC's patient population was drawn from all segments of society. However, because the unit was located in the inner city, most of the clients were from low-income families, both black and white. A few were welfare families; most clients were long-term

[1]From the earliest days of the unit family visits were encouraged, and unlike the policy of the rest of the hospital, children and pets were welcomed.

heroin users (15 years or more). For these reasons the following discussion will focus on family factors among low-income people, the working poor.

A review of the literature of family issues and drug abuse has indicated that most investigators have focused on a few variables that have been found to be common among most drug abusers. Pathological relationships with mothers is the most common finding, especially with young male abusers. The mothers are described as being overindulgent, overly ambitious, and overprotective of their sons, as well as receiving unconscious gratification from the son's deviant behavior. Fathers are said to be minimally involved with the sons or absent (Klagsbrun and Davis 1977; Alexander and Dibb 1975; Blum et al. 1972). While it is probable that these and other factors may be present in the lives of many substance abusers, the experience at DARC was that these factors have little predictive power. The fact that the families of substance abusers could not be typed into neat categories of psychopathology turned out to be a good thing in the long run at DARC, for it prevented the staff from attaching labels to individuals, as well as avoiding anticipatory stereotyping.

TREATMENT STRATEGIES

Working-class people, typically, do not consider insight therapy as treatment of choice when they have to deal with mental health problems. They tend to be more concerned with practical issues and are, therefore, more likely to be interested in employment, housing, and schooling. It has been said that the poor fail at psychotherapy because they lack verbal skills, and that they come late for or miss appointments. Many middle-class practitioners, faced with this situation, give up on the family and label it incorrigible. Such families are not nonverbal or incorrigible; they simply have different value systems from the therapist. An eavesdropper in any drug program that serves low-income people would be hard put to accuse them of lacking verbal skills, for the language of the poor is richly inventive and colorful.

Family counseling for poor groups must take into account these differences. Staff must be trained to understand that if a family must rely on public transportation to get to the appointments, it is likely that lateness will occur occasionally. Similarly, when family members are reluctant to talk in the counseling sessions, it is wise to remember that the clinic is not the family's "turf"; they may feel shy and embarrassed. A counselor may want to consider an alternative strategy, such as holding the counseling sessions at the family's home, until some degree of "ownership" of the sessions is developed by the family.

Another aspect of working with low-income groups is that called

"blaming the victim" (Ryan 1971). When individuals respond to noxious forces in their environments with deviant behavior such as drug abuse, poor school adjustment, or mental illness we traditionally respond with some strategy for remediation that helps the deviant make a better adjustment to society. The onus for change is clearly placed on the "victim" instead of on the agent that produced the harmful effect. Admittedly, it is beyond the province of individual counselors to correct the social ills that have affected their clients, but certainly they should be aware of the ramifications of such forces and, above all, assure the families that concern about such issues is appropriate to discuss at the counseling sessions.

I have raised these issues to indicate some of the problems that have led to treatment failure with poor families. In spite of the problems, we have found that family counseling is an effective adjunct to the treatment of substance abusers.

At DARC there were various types of family constellations, with the drug abuser appearing in several roles. Because the majority of patients were in their twenties, a fair number of them were parents and considered *spouse and children* to be their primary family group. The other major constellation was that in which the patient was the son or daughter, and *parents and siblings* were the primary group. Counseling was provided for married and unmarried couples.

It is interesting to note that as word got around that family counseling was available, we received requests for counseling from parents whose drug-abusing children were not, and not likely to become, our patients. The staff formed a group of these parents; for the most part they wanted information about drug abuse. A few were looking for advice about dealing with their drug-abusing teenagers and how to prevent the abuse from spreading to younger siblings. These activities were seen as a community service and earned some good will credits for the clinic.

The treatment used in these sessions included some of the now traditional techniques of family counseling such as communication exercises, sculpture, role play, and just talking. The staff used approaches appropriate for the families' level of understanding and awareness, and allowed nontraditional approaches to be used wherever indicated. Referrals were made to other agencies whenever necessary. Counselors functioned as advocates on behalf of the clients with other agencies on occasion, and they helped with employment and other problems as needed. Without this willingness to engage in a variety of activities, attempts to work with this particular group of families would probably have been limited to the type of situation where the family attended the clinic only because it was required, not expecting to get anything out of it.

Some investigators have questioned the value of family intervention

for drug abusers because so many of them are estranged from their families. The experience of DARC was different. *Staff found that patients, even when estranged, longed for a renewal of family intimacy.* It is possible that the liberal visiting policies engendered the willingness of families to get involved. It is possible that some programs have failed in this regard because they have kept clients isolated from their social links for so long. Many programs do not even allow their clients to use the phone for extended periods of time.

REASONS FOR FAMILY INTERVENTION

There are important reasons for drug programs to consider working with the type of families we have been describing. Most people, I think, would agree that substance abuse is one way that many Americans cope with the pressures of modern life. We are a drug-taking society, and it affects us at all levels of economic life. However, we have been, and still are, operating by a double standard of evaluation of the problem. If a middle-class housewife is taking tranquilizers, we say she is depressed; if a ghetto youngster is using cocaine or heroin, we call him a delinquent. Additionally, the lower class, contrary to popular myth, has always been more involved with drug abuse than the more affluent (Helmer 1975). If this is the case, it makes perfect sense for practitioners who work with low-income families to help their clients develop ways in which to deal with and manipulate the elements of their environments they find most stressful.

Elements of the Rationale

The following are just a few reasons that indicate the appropriateness of family counseling for low-income families of drug abusers:

1. *To help the family recognize and deal with the consequences of social injustice.* The results of a study done at DARC show that the most successful patients were from middle-class families (Cutter et al. 1977). This would appear to be because family members had more education and income, in addition to more worldly experience and, therefore, were more able to manipulate resources on behalf of the drug-abusing relative. This is not, as some might think, because of any inherent virtue in middle-class persons. Counseling aimed at helping low-income families develop such awareness and appropriate skills will help to alleviate some of the environmental stress.
2. *To provide continuity of support for the patient in treatment.* For example, drug programs usually have some kind of contractual

agreement with the client for achieving certain goals. These goals usually represent a major change in the patient's lifestyle and can be very difficult to accomplish. If the family has participated in the planning, their resulting commitment will help the drug abuser maintain his direction, especially after he or she returns home. Further, since we can expect the family to know more about the patient's ability and idiosyncracies than the counselors, unrealistic and overambitious goal setting can be avoided. Enthusiastic clinicians have been known, on learning that a client has a high IQ, to try to push him/her too fast, completely ignoring the social context in which the client has to operate.

3. *Sometimes a family consciously or unconsciously sabotages treatment efforts.* Such behavior includes things like excessive demands that the client assume an ideal share of parental responsibility. This evokes a measure of pride in the client, who feels guilty if he/she cannot live up to these expectations, which can lead to discouragement and depression, a sure path back to the old way of coping with stress. Another example is of the wife who has learned to manage the family affairs by herself, but who is now reluctant to share that responsibility, partly out of fear that her husband will not be able to cope with the unaccustomed demands, and partly because of an unwillingness to relinquish power. These issues can be thoroughly aired in the counseling sessions, and a skillful counselor will be able to guide members through the emotion-laden topics with a minimum of acrimony and blaming.
4. *Occasionally a family has an identifiable pathology that is detrimental to its members.* Problems such as alcoholism, violence, and mental illness are not uncommon, and these sessions can help the family learn new ways of coping with them. Serious problems such as psychosis can be confronted directly, and appropriate referrals can be made. This is important since low-power people tend to suffer in silence, often unaware of resources that are available for them to use.

Some Typical Problems

Working with the poor presents some of the same problems found in middle-class families; however, there are some problems that are particularly troublesome when dealing with low-income groups. One problem is getting the family to come to the clinic. Many families prefer to deal with their troubles alone, rather than allowing strangers to know their "business." Clinic staff need to use all their skill and sensitivity in approaching these families.

Some programs have developed very inventive ways of attracting

families. The first rule is to know the population. How do they socialize? What values are important to them? What factors prevent them from coming to the clinic? In one program that primarily served an ethnic group that valued close family ties and maintained large extended family networks, the staff was able to involve the family members in some of the chores of running the residential treatment house. Parents donated and cooked large trays of food, often at considerable personal sacrifice. Other family members helped with renovations. Families, staff, and clients formed a cooperative community with shared goals. It was then just a short step to get the families involved in counseling sessions.

Another problem is the practice of labeling people with symptoms. Many practitioners indicate that personality factors such as motivation and self-image play a role in successful treatment. While these factors possibly do play a role, the problem with them is that many treatment persons would consider them to be issues requiring insight therapy. As mentioned above, poor people do not consider insight therapy as valuable. Yet we found that they *are* interested in learning to cope with problems in a more practical way. In one case, the grossly overweight mother of an adolescent client was given support and encouragement to go to a weight-loss clinic. As she lost weight, her self-esteem improved and she became less involved with her son, a factor that had been prominent in his use of drugs. While we recognize the existence of psychopathology, it is not used as a basis for discussion. A more pragmatic approach acknowledges that all persons have some healthy inner resources which can be developed and used on their own behalf. This is an approach to treatment that is based on respect and promotes self-respect.

After getting the family involved in treatment, another serious problem arises—that of class differences between the staff and clients. Many counselors are from middle-class backgrounds and are not really familiar with the intimate details of the lives of poor racial and ethnic minorities. Even when the staff come from the same background as the clients, the fact that they are in the psychotherapy field is an indication that they have, at least in part, bought into middle-class values and that, therefore, their perspective has been altered with regard to the way they relate to their clients. These differences cause communication failures which are frustrating for both staff and clients. Staff may give up on the family prematurely. Hollingshead and Redlich (1958) describe in detail how class differentials affect the type and quality of treatment in the mental health system.

Drug program staff see themselves, correctly, as an alternative to the traditional way of doing business. Yet there still persists a tendency to focus on intrapersonal problems, and to neglect cultural and

social concerns that are of equal importance when dealing with low-income families. Working in multifamily groups can do a lot to ease this problem, because they form a natural support group that outnumbers the counselors. This gives the clients an edge in being able to bring up their own issues. In other words, it increases each member's power and influence in alien territory.

In conclusion, family counseling for drug abusers is a valuable treatment, especially for low-income families who often need all the support and advocacy they can get. It will be successful only insofar as the counselors are willing to acknowledge that social injustice has affected their clients and that, as a result, they have developed a view of the world that differs from the counselors' view.

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9. The Family-Drug Abuse Relationship

Richard R. Clayton, Ph.D.

INTRODUCTION

The drug abuse field was shaped somewhat hastily during the late 1960s and early 1970s, with the expectation that its leaders would deal decisively and maturely with a major social problem. The level of performance expected from the White House Special Action Office for Drug Abuse Prevention and later the National Institute on Drug Abuse (NIDA), and demanded by the gravity and scope of the problem, left little time for rational long-range planning and a deliberate developmental pattern of growth. The early stages of growth occurred almost simultaneously with the emerging crises produced by the multifaceted nature of drug use, misuse, and abuse in the United States. The early geometric growth of the field through a proliferation of research efforts, demonstration projects, and treatment delivery services has begun to level off. It is possible now, for the first time, to take inventory of the progress made to date and to explore in a more systematic fashion the areas of concern that could/should be part of the research, prevention, and service delivery agendas within NIDA and the drug abuse field for the 1980s. One such area of concern is *the intersection of the family*[1] *and drug abuse.*

At least two assumptions are implied by the general purpose of this monograph and the guidelines for the contributed papers: (1) a policy decision has been made to expand NIDA's interest in and concern for

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[1]In this paper the term "family" denotes living and social arrangements in which a milieu of kinship and intimate support is assumed present (e.g., marital or cohabitating dyads, nuclear units, single-parent families, etc.)

the family-drug abuse connection; and (2) the policy decision is being translated into programmatic thrusts that will be operative in NIDA's prevention, research, and service delivery efforts in the 1980s.

These assumptions, if they are correct, indicate a shift in orientation at NIDA from an almost exclusive focus on the individual drug user toward greater interest in the contexts within which drug users function, one of which is the family. Based on my disciplinary identification (sociology of the family and drug abuse) and my research experiences (primarily survey), the primary purpose of this paper will be to examine some of the factors that justify a focus on the linkages between the family and drug-abusing behaviors. This will be accomplished in three sections dealing with (a) current drug abuse policies at the Federal level and their limitations; (b) changes in the parameters of drug use and abuse; and (c) recent changes in the family in the United States.

CURRENT DRUG ABUSE POLICY AT THE FEDERAL LEVEL

Current Federal policy on drug abuse is built around two interlocking strategies. The first, supply reduction, emphasizes the interdiction of illicit drugs (mainly heroin, cocaine, and marijuana) and rigorous enforcement activities directed toward major drug trafficking operations. The underlying assumption is that a reduction in supply will yield higher prices for lower quality drugs (i.e., incentives for leaving the illicit marketplace). The second strategy, demand reduction, emphasizes the availability of drug abuse treatment facilities and care for those who either desire it or who have been diverted involuntarily into treatment from other systems. The assumption is that a short supply coupled with high prices and low quality will lead addicts into treatment, if it is available.

The Federal strategies (i.e., policies) were formulated to deal with unique sociohistorical and political conditions. In the mid- to late 1960s and early 1970s the United States endured a youth revolt resulting partially from the passage of the baby boom generation through late adolescence and early adulthood, a period of relative affluence, the turmoil and strife associated with the Vietnam War, the Watergate crisis, and a drug epidemic of serious proportions visible for the first time in white, middle-class, suburban America.

Given these precipitating conditions, the dual Federal strategy of supply and demand reduction served as a useful organizing framework. It put the drug abuse problem(s) as then perceived into perspective. However, there are now *new* contingencies, and *different*

sociohistorical and political realities that must be dealt with effectively if the drug abuse problem is to be contained. Drug abuse as a social phenomenon has itself changed. What is needed is a fresh and new look at the old Federal strategy. It is time now to set new agendas, to prioritize Federal drug policies in order to address adequately the social and political realities of the 1980s and the changed/changing face of drug use in the United States.

CHANGES IN THE PARAMETERS OF DRUG ABUSE

This section of the paper is designed to review changes in the parameters of the "drug problem" in the United States as we enter the 1980s, and to show why such changes argue persuasively for recognizing the family as an important locus of concern for Federal drug abuse policies—for making the family a visible and viable part of the Federal drug strategy, especially on the demand reduction side of the ledger. At the program level, the crux of the argument is that the family should be considered part of NIDA's research, service delivery, and prevention activities.

Use of illicit drugs, once a statistically uncommon occurrence, has been increasing, especially among youth and young adult populations. This is seen quite clearly in table 1, which shows data from five national surveys conducted in 1971, 1972, 1974, 1976, and 1977, dealing with the lifetime prevalence of marijuana use among youth 12-17 years old and among adults 18 or older. The lifetime figures for adults moved from 15 percent in 1971 to 1 in 4 or 25 percent in 1977, a significant increase. Among youth 14-15 years old in 1977, almost one in three had used marijuana, while among those 16-17 years old the figure was close to one in two; males were more likely to have used marijuana than females. Among 18- to 25-year olds 60 percent have tried marijuana while 44 percent of those 26 to 34 years old have used the substance at least once.

The figures for youth are congruent with those obtained by Johnston et al. (1978) from a nationwide sample of high school seniors. Some 59.2 percent of the senior class of 1978 had tried marijuana; 64 percent of the males and 54 percent of the females. Of perhaps more significance than the lifetime prevalence of marijuana use is that 10.7 percent of these high school seniors report *daily* use of marijuana compared to 5.7 percent reporting daily use of alcohol. In behavioral terms then, at least for high school seniors and young adults, the data indicate that use of marijuana is normative—i.e., illegal but not statistically deviant.

The extent of nonmedical use of other illicit drugs by high school

TABLE 1.—*Prevalence of marijuana use, selected national surveys, for adults and youth by age, sex, and race (in percent)*[1]

	1971	1972	1974	1976	1977
All adults, 18+	15	16	18.9	21.3	24.5
Age					
18-25	39	48	53	53	60
26-34	19	20	30	36	44
35+	7	3	4	6	7
Sex					
Male	21	22	24	29	30
Female	10	10	14	15	19
Race					
Whites	15	15	18	21	24
Nonwhites	15	21	27	25	27
All Youth, 12-17	14	14	22.6	22.5	28.2
Age					
12-13	6	4	6	6	8
14-15	10	10	22	21	29
16-17	27	29	39	40	47
Sex					
Male	14	15	24	26	33
Female	14	13	21	19	23
Race					
White	15	16	24	22	29
Nonwhite	12	5	17	22	26

[1]From Herbert I. Abelson; Patricia M. Fishburne; and Ira Cisin. *National Survey on Drug Abuse:1977*. DHEW Pub. No. (ADM) 78-618. National Institute on Drug Abuse. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1977. Tables 24 and 25.

seniors is not insignificant. The lifetime prevalence figures are: inhalants, 13 percent; hallucinogens, 15.6 percent; cocaine, 14.1 percent; heroin, 2 percent; other opiates, 12.6 percent; stimulants, 24.4 percent; sedatives, 17.3 percent; and tranquilizers, 18.4 percent. Over 90 percent had used alcohol, and 3 out of 4 had used cigarettes.

These data indicate then that drug use among high school seniors is not limited to alcohol, tobacco, and marijuana. A number of other substances are being used as well. Some of these are potentially habit-forming and are especially dangerous when used in combination with alcohol.

The implication of these findings from a policy standpoint is that prevention and demand reduction activities and efforts must be broadened. The respondents in these studies are not dropouts, delinquents, addicts, or those caught up in the criminal justice systems. They are representative of that part of the American population that lives in households, in family units. They represent suburban middle-

class American families, and a universe that may never appear in *any* of the health system catchment units, yet they may have drug problems requiring some kind of treatment. Given the relative proportions of the population that are white and living in relatively stable and intact households, these data suggest a refocusing of drug prevention and treatment efforts toward the *majority* population.

The population utilizing drug abuse treatment facilities is changing dramatically, necessitating a reappraisal of the target populations for the demand reduction part of the Federal strategy. As noted earlier, the Federal treatment apparatus was designed to deal with a heroin epidemic of great proportions that occurred in the late 1960s and early 1970s; the target population was primarily those addicted to heroin. The ultimate goal was to rehabilitate; a more pragmatic goal was to reduce or at least curtail *daily* use, concomitantly reducing the amount of criminal activity needed to support a heroin habit.

Most of those caught up in the treatment net during the early expansion period of the Federal strategy were first-timers, young, and black. During the last quarter of 1977, some 53 percent of all clients admitted to Federal treatment programs had *prior treatment experience.* For those whose primary drug at admission was heroin/opiates, only 30 percent had *never* been in treatment; 26 percent had 3 or more prior treatment experiences. The extent to which the treatment population has changed can be seen in Dade County, Florida (McCoy et al. 1979) where data show that the percentage of all heroin treatment admissions with prior treatment experience has risen from 33 percent in 1974 to 71 percent in 1978. Simply put, entrance into treatment is a recurring experience for a substantial part of the heroin addict pool. In classic epidemiological terms, those currently addicted are not "infecting" enough new users to claim that the epidemic is still expanding. At least for heroin, the epidemic is contracting. It will be increasingly difficult to justify support for a treatment apparatus that is primarily serving heroin-addicted clients who previously have received treatment. Perhaps it is time for a reevaluation of the populations served and the types of services rendered.

Another way that the population utilizing drug abuse treatment facilities has changed is in the sex ratio. This is not readily apparent when one examines national data from the Client Oriented Data Acquisition Process (CODAP). In the last quarter of 1977, 72 percent of all clients admitted to drug treatment were male, 28 percent female. This is about the same as that found during the height of the "epidemic." The percentages by sex for *primary drug* of abuse at admission are: opiates, 73 percent male; alcohol, 86 percent male; barbiturates, 65 percent male; amphetamines, 66 percent male; marijuana, 71 percent male; cocaine, 76 percent male; all other drugs, 65

percent male. The primary difficulties in interpreting these data are: (a) first admissions are not separated from those with previous admissions; (b) a comparison of first admissions by sex and over time is not readily available from Federal statistics. However, recent data from major methadone maintenance clinics in Dade County, Florida, indicate that about 60 percent of all first admissions for heroin are now women. The reversal in sex ratio among clients is so significant that several of these clinics will soon be providing a short-time day care center for the children while the mothers wait for their methadone. This situation is occurring in clinics where the primary drug of abuse is heroin.

If one focuses attention just on heroin-abusing women, the problem is serious. Conservatively, 20 percent of all addicts in this country are female. Given the latest NIDA estimates, this means there are well over 100,000 heroin-addicted women in this country, most of whom are between 18 and 30, and many of whom are mothers (Cuskey et al. 1978).

The drug abuse treatment population in the United States has changed dramatically in recent years and is still changing. First, it is getting older as evidenced by the proportion of all admissions that are readmissions. Second, the sex ratio has switched from 7 out of 10 or more being men, to a situation where the largest proportion of all first admissions is women. Third, most of the women being admitted are multiple-drug users and are in the prime childbearing and childrearing years. Fourth, while little is known about the "hidden" prevalence of abuse of various drug classes, it is likely that, in terms of numbers alone, there is a significant and only partially hidden problem concerning abuse of prescription drugs in this society. This type of drug misuse-abuse is likely to occur most often among women who may never go near a drug treatment facility. Evidence concerning the fourth point above is available from the Drug Abuse Warning Network (DAWN) data on drug related medical emergencies gathered in hospital emergency rooms around the country. From May 1976 through April 1977, of 121,077 patients, 59 percent were female and 57 percent of the females were 20-40 years old.

In table 2 data are presented on the top 20 drugs, in order, in terms of number of times mentioned by emergency room patients, and the distribution for each drug class by sex of patient.

Several things are clear from these data. First, males are decidedly predominant for only 5 of the 20 drug classes—heroin, methadone, marijuana, PCP, and cocaine. With the possible exception of methadone, all of these drugs are available primarily from the illicit market; however, except for heroin, most of these illicit drugs account for relatively small proportions of the mentions in emergency room episodes. Second, 10 of the 20 drug classes fall under the general

TABLE 2.—*Rank order of drug mentions by sex and drug class: Drug Abuse Warning Network data, 1977*[1]

Drug classes and brand or generic name	Numbers of mentions	Percent by sex	
		Male	Female
1. Diazepam (Valium)	21,774	32	68
2. Alcohol-in-combination	19,095	48	52
3. Heroin-morphine	12,753	67	33
4. Aspirin	7,027	27	73
5. Flurazepam (Dalmane)	4,596	28	72
6. d-Propoxyphene (Darvon, Dolene, SK-65)	4,339	28	72
7. Chlordiazepoxide (Librium, Libritabs)	3,725	31	69
8. Methadone	3,348	66	34
9. Phenobarbital (Luminal, Eskabarb)	3,070	39	62
10. Amitriptyline (Elavil)	2,994	27	73
11. Secobarbital (Seconal)	2,967	45	55
12. Secobarbital/Amobarbital (Tuinal)	2,912	45	55
13. Marijuana	2,267	65	35
14. Methaqualone (Quaalude, Sopor)	2,201	52	48
15. Ethchlorvynol (Placidyl)	2,008	42	58
16. Acetaminophen (Tylenol, Nebs)	1,b.8	24	76
17. PCP	1,647	70	30
18. Perphenazine/Amitriptyline (Etrafon, Triavil)	1,522	24	77
19. Cocaine	1,420	67	33
20. Clorazepate (Tranxene)	1,337	22	78

[1] From Drug Enforcement Administration. *Project DAWN V*. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1977, Table 2.9.

heading of sedatives: tranquilizers (numbers 1, 7, 18, and 20), barbiturate-sedatives (numbers 9, 11, and 12), and nonbarbiturate-sedatives (numbers 5, 14, and 15). In the overwhelming majority of cases where the *source* of these sedative-type drugs was known to emergency room personnel, the patients received these drugs via legal prescription. One observer, Lader (1978), has called drugs like Valium, Librium, and Darvon the "opium of the masses." This may be an appropriate analogy, especially if one considers the scope of the drug-use-misuse-abuse problem in the United States in terms of gross numbers affected, the direct and indirect costs associated with the problem, the potential long-term effects from a socialization of children and role-modeling perspective, and the question of how the drug problem of the 1980s may differ from the drug problem of the 1960s.

The data and discussion presented above suggest that the demand reduction strategy at the Federal level may need to be reformulated and retargeted. This does not imply that the revolving treatment door for long-term heroin addicts should be stopped. While not markedly

successful in "rehabilitation," the treatment system does seem productive in reducing some of the associated costs of drug abuse (e.g., criminality, inpatient medical care) through periodic detoxification. A refocusing of drug abuse treatment efforts is appropriate because the problem of drug misuse-abuse in this country is in a state of transition. To understand more precisely the changes that have occurred and seem to be occurring requires that (a) the characteristics and needs of clients entering drug abuse treatment for the *first* time be fully assessed, and (b) serious attempts be made to estimate the extent of drug use, misuse, and abuse of both licit and illicit drugs in the United States.

If this were done, those with the responsibility for developing and implementing Federal drug abuse policies would quickly recognize the salience of the familial context within which drug use, misuse, and abuse are anchored. The result would be research, prevention, and treatment efforts supporting drug abuse policies tailored for the 1980s, not the late 1960s.

The passage of the baby boom generation through the societal age structure has important implications for integrating the family into drug abuse policies and programs. Although the drug abuse problem of the late 1960s and early 1970s was clearly an epidemic in the usage of drugs, it was much more. For example, O'Donnell et al. (1976) set the starting date of the epidemic as 1968 with marijuana, and the apex of the epidemic as 1972 with cocaine. Simple arithmetic will indicate that in 1968 the 1950 birth cohort was 18 years old. The baby boom that began in 1946 peaked in 1957—with the boundary ages in 1968 being 22 years old (1946 cohort) and 11 years old (1957 cohort). In 1980 the 1946 cohort will be 34 years old, the 1957 cohort 23 years old, and the 1950 cohort will be at the great transition point—30 years old. It is likely that the aging of the treatment population reflects the passage of those born in the baby boom era through the health care system just as they are passing through the society. The increasing proportion of women as first admissions to treatment for opiate addiction suggests that "heroin infection" is no longer spreading through the males at-risk and is, in classic epidemiological terms, regressing toward an endemic stage or state of relative remission. However, these trends may reflect a drug problem potentially more serious and far reaching in its impact on society.

This *new* problem has the following dimensions. First, we now have in the general population a large proportion of persons who, in their youth, used illicit drugs for recreational purposes or as part of a lifestyle in rejection of "the establishment." They may be continuing their use of illicit drugs for the same reasons or as a coping strategy. Further, that bulge in the population structure is well into the marry-

ing, childbearing, and childrearing years. This fact is of prime importance for the development of drug abuse prevention and treatment policies in which there is a consideration of the impact of family factors on the initiation, continuation, or cessation of use of illicit drugs, and how these drug-using behaviors impact on families. The questions are: (1) Will these historically unique individuals mature out of drug use as they experience adult roles and responsibilities, or will they continue behaviors developed in conjunction with drug use? (2) What kinds of role modeling and explicit socialization concerning drug use will be transmitted to the children of the baby boom generation? (3) What would happen to the drug use patterns of these individuals if the illicit drug supply were suddenly substantial again and the quality was good? (4) What are the long-range health consequences and costs that society must bear as a result of the simultaneous historical occurrence of the drug epidemic with the demographic revolution we call the baby boom generation?

THE PARAMETERS OF FAMILY

The literature concerned with linkages between drug abuse and the family is diffused, fragmented, and in need of a critical assessment. Research scholars are more likely to specialize in one of the two substantive fields, drug abuse or family, than on the connecting links between the two fields. Before we can identify adequately the prevention, research, and service delivery options available to NIDA in dealing with the family and drug abuse, it is essential that the family, its meaning, components, dimensions, and how they are changing be more specifically identified. It is possible to identify at the macrosocietal level trends in marriage and the family that may be potentially significant vis-a-vis drug use, misuse, and abuse in the United States.

- There has been a decrease in recent years in the marriage rate; a larger proportion of the population is single and/or postponing marriage.
- There has been an increase in the median age at first marriage for both men and women.
- There has been an increase in the proportion of all marital couples who are voluntarily childless.
- There has been a marked increase in the divorce rate yielding estimates that 1 in 3 of all first marriages will eventually be terminated by divorce.

- There has been a decrease in the average duration of first marriages that end in divorce.
- There has been an increase in the proportion of all households that are female-headed, especially among nonwhites.
- There has been an increase in the proportion of all women with dependent children who are in the labor force.
- The extent of illegitimacy has increased in recent years, and this is more true for nonwhites than for whites.

These changes are significant for two reasons. First, they reflect a legal and sexual parity in structural types of relationships. Health-related consequences of such equality include increases in the incidence of cardiovascular diseases and cancer among women, and a convergence of males and females in smoking and drinking practices. Second, these trends reflect basic changes that are occurring in the timing and patterning of social roles. As many researchers have documented, the timing of entry into particular roles has important consequences for other roles, whether or not the other roles will be assumed, the levels of attainment, and the continuity of participation in these roles.

At this time very little is known about how patterns of drug use affect participation and timing of entry into the labor force, marriage, or parenthood; and correlatively, how participation in social roles affects patterns of drug use. Transitions into various roles themselves may affect drug use. The type of role transition as well as its place in the configuration of the individual's roles may have further consequences for drug use. Thus, marriage may be followed by a decrease in drug use. By contrast, certain transitions that are more stressful and sometimes perceived as crises may be associated with increases in certain types of drug usage. Drug use in adolescence may cause perturbations in the timing of entry into or exit from certain roles (causing either accelerated or delayed entry), these in turn having further social, psychological, and behavioral consequences. The crucial point is that the interaction between achievement of sexual parity, changes in the timing and patterning of social roles, and increasing levels of drug use have important implications for drug abuse policies and programs—implications calling for greater interest in and concern for the impact of the family on drug use and drug use on the family.

The macrosocietal-level trends in marriage and the family discussed above are perhaps more important for policy and program needs assessments than for the design of prevention, research, and service delivery efforts concerned with drug use and abuse within

families. These trends are for the "general population" defined broadly. Neither drug abuse nor the family contexts most conducive to drug abuse are equitably distributed across the population. This is most evident when one examines some of the sociodemographic and family characteristics of clients in drug abuse treatment facilities.

Data from the Client Oriented Data Acquisition Process (CODAP) indicate that women are underrepresented in drug abuse treatment relative to their proportion in the population, particularly with regard to opiates, alcohol, and cocaine. They are more likely to be in treatment for abuse of amphetamines and barbiturates, but still constitute only 32 percent of total clients for these drugs. The data in table 3 indicate quite clearly that those clients in treatment for marijuana, amphetamines, and barbiturates are considerably younger than those in treatment for the opiates, alcohol, and cocaine.

The data on race-ethnicity are particularly noteworthy. While blacks constitute only 13 percent of the total population in the United States, they account for 34 percent of all clients in treatment and for 46 percent of those in treatment for abuse of opiates. In the opiate category persons of Hispanic origin account for 15 percent of treatment clients, a figure considerably larger than their proportion in the total population.

The figures on family status reveal that 36 percent of all clients in the federally supported drug abuse treatment system are living with parents and 18 percent are living with a spouse. Slightly over one in five clients are married while another 21 percent are either separated or divorced.

Drug use and abuse have pervaded every segment of American society (Johnston et al. 1978; Abelson et al. 1977; O'Donnell et al. 1976). No person or family is immune from the pressures, direct and explicit or indirect and subtle, to use drugs as an aid in coping with the exigencies of modern society. The data presented above on family and sociodemographic characteristics of drug abusers, and the data presented earlier on the changing patterns of drug use and abuse, reveal the great potential to be realized *if* the family is used as a vehicle through which prevention and service delivery efforts are directed.

THE FAMILY AND DRUG ABUSE: SETTING AGENDAS

The changes and trends in drug use and abuse and in marriage and the family discussed above reflect complex realities indicating *why* the family-drug abuse linkage should be considered in formulating and implementing policies and programs at NIDA in the 1980s. It is neither feasible nor politic, however, to assert that NIDA should inte-

TABLE 3. *Percent distribution by sex, age, race-ethnicity, and living arrangements by primary drug of abuse at admission: January—March 1977*

	Primary drug at admission							
	All clients	Opiates	Alcohol	Barbiturates	Amphetamines	Marijuana	Cocaine	All other
Sex								
Male	73	73	83	68	68	74	81	65
Female	27	27	17	32	32	26	19	35
Age								
Under 18 years	9	1	9	20	16	39	8	28
18-20 years	11	5	8	21	21	27	20	21
21-25 years	30	34	14	32	31	21	37	25
26-30 years	27	35	16	16	19	9	21	12
31-44 years	18	22	26	9	11	4	12	10
45 years and over	5	3	27	2	2	0	1	4
Race/Ethnicity								
White (not of Hispanic origin)	52	38	73	81	85	72	59	80
Black (not of Hispanic origin)	34	46	21	10	9	17	31	8
Hispanic-Mexican	7	9	2	4	3	5	2	7
Hispanic-Puerto Rican	4	5	2	1	1	5	5	2
Others	2	1	1	4	2	3	3	4
Marital Status								
Never Married	57	48	48	71	67	85	70	71
Married	22	27	23	12	13	8	13	13
Widowed	1	1	2	1	1	0	0	1
Divorced	11	12	18	10	13	4	10	8
Separated	10	12	9	6	7	3	6	6
Living Arrangements								
Living Alone	14	16	19	12	14	6	16	10
Living with Parents	36	28	33	45	42	63	35	52
Living with Spouse	18	23	20	10	9	7	10	12
Living with Others	32	33	28	33	35	24	40	26

From National Institute on Drug Abuse. *Quarterly Report, January—March 1977: Data from the Client Oriented Data Acquisition Process (CODAP)*. Statistical Series, D, Number 2. Rockville, Md.: the Institute, 1977, tables 2-4.

grate the family into its varied activities without indicating *what* can be done and *how*. Given the dearth of information currently available on the family-drug abuse connection, this is a difficult task. However, within the two broad domains of research and prevention, the following tentative agendas are offered as a beginning.

Research Agenda: A Broad Outline

At the heart of a research agenda concerned with the linkage between family and drug abuse are epidemiological questions about incidence and prevalence—questions requiring descriptive data.

1. Information is needed on exactly what the familial contexts are for those involved in various drug treatment modalities in the United States. For example, among the 36 percent of clients in the CODAP system who report living with parents: Are these individuals living with both parents, or with the father alone or mother alone? Are other adults present in the family and if so, who are they? Among the 22 percent of clients who are married: How long have they been married? Do their partners use drugs as well? Which came first, dependence on drugs, or marriage? How many children are present within these homes?

   These kinds of questions and others like them must be addressed if we are to understand the association between drug abuse and the family context. Answers to such questions could be obtained through a sampling of clients and special studies added to the regular CODAP reporting procedures. The purpose of such studies would be "needs assessment" in focus. The answers derived from such a study of CODAP clients might suggest new forms of outreach or service delivery not now part of the treatment effort.

2. Information is needed on the simple correlates and possible predictors of drug use and abuse, one set of which may be related to family and marital status. A great deal of descriptive data are gathered via the CODAP system and the NIDA national surveys; generally, the only type of analysis conducted is purely descriptive—marginals in the form of percentages. It would be instructive for NIDA to apply more sophisticated multivariate statistical techniques (i.e., correlation and partial correlation as well as multiple regression) to these data sets.

3. Information is needed on the hidden prevalence and correlates of drug use and misuse within the general population. While useful in providing general benchmarks, the NIDA national survey is limited because of sampling and other design constraints in arriving at a

closer approximation of the *total* extent and configuration of drug use-misuse-abuse in America. Systematic and concerted efforts should be undertaken to estimate the hidden prevalence of drug abuse. *Who* is abusing *what* drugs, what are the *sources* of these drugs, and how can these hidden abusers be provided with treatment services? The primary focus for such efforts should be on alcohol and the benzodiazepines, and the marital and familial contexts associated with abuse of these drugs. Research on this type of problem, where drug use and family are clearly related, will be most productive if conducted within specific communities as opposed to being "national" in scope.

4. Information is needed on the relationship of drug misuse/abuse, and role and life-cycle transitions within the family. In recent years a great deal of scientific interest has emerged concerning stages in the adult life cycle (Levinson et al. 1978; Gould 1978) and what has been called "mid-life crises." If drugs are used as a means of coping with stress generated by changes in roles and responsibilities, such coping usually occurs within the context of family, and the consequences of such may affect interaction and socialization patterns within the family. Research addressed to interaction of life-cycle transitions and drug use could be a part of the kinds of studies suggested in point 3 above.

5. Beyond descriptive epidemiological questions in a research agenda are questions of etiology, which would lead to an unraveling of the "causes or predictors" of drug use and abuse. While it would be desirable from a scientific perspective to initiate a number of prospective longitudinal studies, such studies are expensive and take a long time to complete. A feasible alternative is to field a number of quasi-longitudinal studies (i.e., cross-sectional across several adjacent birth cohorts) to examine predictors of drug use and abuse. If a lifespan developmental framework were used (see point 4 above), it would be possible simultaneously to search for predictors of drug use-misuse-abuse among youth, young adults, and those in early, middle, and late adulthood as well as the elderly. A key focus of such studies should be the family contexts within which drugs are used and whether certain types of family factors are predictive of use. If these studies were coordinated and complementary, it would be possible to obtain at least partial answers to difficult questions rather quickly.

   As a precursor to such efforts it would be productive to convene a small group of researchers who have data sets relevant to the issue to obtain their advice on how to design the necessary studies. In recent years NIDA has funded a number of studies that meet this cri-

terion. It is likely that results from these studies can be pooled to provide a tentative guide as to which family factors seem to be most predictive of drug use and abuse. Family variables associated with the *cessation* of drug use/abuse may also be identified.

Prevention Agenda: A Broad Outline

The most important emphasis for drug abuse policies, programs, service delivery, and research should be prevention. However, prevention is a tired word, universally endorsed as a principle and seldom defined explicitly. In the drug abuse field there has been a tacit assumption that prevention is equivalent to education, media spots, and catchy slogans in prevention "campaigns." While these are no doubt important vehicles in the prevention process, prevention should include more than just public relations efforts.

There are at least two levels at which prevention efforts in the drug abuse field should be operative, both of which can utilize the family as the arena of action. The first is *primary prevention.* Primary prevention refers to intervention occurring prior to the emergence of the behavior seen as damaging or undesirable. The natural context for primary prevention efforts is the family unit that includes youth entering the years in which drug use/abuse will most likely begin. The focus of such efforts should be twofold. First, family members need to have opportunities to learn how to make rational choices among the behavioral options open to them. This requires the development of intervention materials outlining: (a) the available behavioral options, (b) the consequences of various options from health, psychological, sociological perspectives, and (c) criteria to use in choosing one option vis-a-vis other options available. Evaluation of primary prevention requires demonstrations in which the research design is built upon random assignment into experimental and control groups, longitudinal followups, and rigorous statistical analysis. The logical locus of such efforts should be family units since most who enter illicit drug use do so while still living within the confines of family roles and responsibilities.

A second level at which prevention efforts should be operative is called *secondary prevention.* In the drug abuse field this takes the form of treatment intervention. As noted earlier, most secondary prevention efforts are directed exclusively at the individual users/abusers rather than at the marital or familial unit to which he or she belongs. There is a pragmatic reason for focusing on the individual. Federal funding mechanisms support individual "slot" costs, as opposed to treatment unit costs. Thus, the Federal funding formula may provide a disincentive to utilize system-based therapies, with the end result

being a tendency "to penalize programs that attempt to do effective therapy with the patient and his family" (Kleber 1977, p. 271). This is particularly unfortunate; the family is so intimately involved in the life cycle of addiction experienced by its members that Stanton (1979) suggests there is a *family* addictive cycle when one or more members of a family are addicted. Stanton's argument underscores the importance of the intimate support network for persons exhibiting pathological forms of behavior. Moreover, on gross numerical grounds alone a case can be made for fully integrating marital and family therapy into the secondary prevention repertoire of the drug treatment system.

Drug abuse prevention efforts have been uniformly less than successful because of a pervasive myopia among both prevention specialists and researchers. It is time for productive interaction and collaboration among these groups to begin. It is possible that new insights and approaches to both primary and secondary prevention would emerge from a coordinated and systematic evaluation of the results of ongoing longitudinal studies (see point 5 under section on research agenda). Drug abuse is too serious a problem for researchers to ignore and too complex for prevention specialists to tackle alone. Prevention is/should be everybody's concern.

CONCLUSIONS

After a period of phenomenal growth and expansion, the drug abuse field and NIDA have reached a point where it is possible to take an inventory of "progress to date" and systematically to determine what will be the priorities for the 1980s. In this paper the purpose was to examine the linkages that exist between the family and the drug abuse. This purpose was accomplished by (1) a brief review of the supply and demand reduction policy strategies, (2) a discussion of changes in the parameters of drug abuse, (3) a discussion of changes in the parameters of family, and (4) a presentation of a broadly outlined research and prevention agenda.

Any review of the drug abuse literature would reveal that far less attention has been directed toward understanding the relationship and connection between drug abuse and a relatively stable institution like the family than is true for something like the drug-crime relationship, where both phenomena are considered social costs. This lopsided situation is understandable when one examines the brief history of drug abuse as an emergent social problem (Josepheson 1974). However, extrapolating from the various sections of this paper, it is safe to conclude that drug use and abuse in the United States are not phenomena that will just vanish; neither can they be quarantined.

Drug use and abuse exist in all segments and layers of society; from predominantly rural areas to tenements and penthouse apartments in our biggest cities; among young and old; among the rich, the middle class, and the poor. Nevertheless, drug use and abuse do seem to discriminate according to socioeconomic status, race-ethnicity, and sex, being disproportionately more prevalent among the poor, blacks and members of other ethnic minorities, and males. One factor common to all, users and nonusers alike, is experience within family contexts.

Logically extending from these conclusions are two crucial questions: (1) What can or should be done to understand more completely the family-drug abuse relationship? and (2) how can or should the family be integrated into Federal drug policies and research, prevention, and service delivery efforts?

While tentative answers to these questions are implied in the discussion above on research and prevention agendas, the history of Federal efforts to solve problems seemingly associated with and anchored in the family is strewn with the remains of many well-intentioned efforts and programs. It is important, then, for researchers to approach the problem recognizing that the linkage between the family and drug abuse is quite complex, and for the policymakers and program planners to show prudent restraint in attempting to deal with what they "think" is the family-drug abuse relationship. We must immediately take *bold* and innovative *strides* toward understanding how the family and drug use/abuse are connected, but we must do so with meticulous care and deliberate caution.

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10. An Argument for Family Research

Richard H. Blum, Ph.D.

Herein I argue that there has been insufficient research on family factors in drug abuse origins and treatment. I hold that this insufficiency is demonstrable and, further, that the reasons for comparative lack of work are not entirely scientific, but arise from sociocultural variables affecting the choice of work areas by investigators and clinicians. I further argue that there is strong empirical reason to expand work that tests interventions with families, either preventively, concurrently with other approaches, or in clinical treatment and rehabilitation.

It has been my impression that family research or clinical work occupies a minority position in the social sciences. Certainly there have been powerful studies that have focused on the family as such; indeed most of anthropology's beginnings (Boas, Krober, Malinowsky, Mead) rest upon family and kinship conceptions, and it is the heart of some of the best early sociology[1] as well as current family sociology as such. In early creative psychiatry family conceptions are critical elements; there is no psychoanalytic theory indifferent to parent-child interaction, nor is related personality theory—from Horney to Murray—possible without an examination of developmental interrelations. With such strong beginnings, one would expect a continuing powerful trend throughout the social sciences, certainly in those which by their sub-

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[1]Thomas Znaniecki on the Polish peasant, Durkheim on suicide, Frazier on the black family.

ject matter must attend to the psychopathology and aberrant behavior of young people as well as to normal conduct. The fields of drug abuse and alcoholism, when not biological or epidemiological, are those where one would expect a strong interest in family factors. One need not expect a dominant focus—behavior and pathology are certainly too complex for that—but one would look for at least a consequential thrust, Nevertheless, even that is absent.

Let me illustrate, using a casual but instructive example. I took from my shelf the *Psychological Abstracts* index volumes for 1970 and for the last half of 1978. The 1970 volume runs about 80 citations per page, the 1978 volume about 60. Total entries, as I estimate them from citations multiplied by pages, are about 65,500 for 1970, and the same for half of 1978. (One learns there that over 8 years the abstracts have doubled their content and increased the detail of their entries.)

I counted, first, drug abuse-related entries, excluding "alcoholism" as an index item but including articles noting alcohol topics when these appeared under "drug abuse," "addiction," "drugs," and the like. I estimated after inspection that about 25 percent of the "drug effect" studies are concerned with drug abuse as such. In 1970 there were about 100 drug abuse entries, whereas for half of 1978 (the half-year index volume) there were 750, or extrapolating, 1500 for the full year. In the abstracts, entries are multiple for the same article because of cross-indexing. I assumed that there are three entries for each article because of cross-indexing. Therefore (a guessing error here does not matter as long as the ratio is constant from year to year), there would be 22,000 actual articles cited in 1970 and the same for the last half of 1978. If so, then in 1970 drug abuse articles account for 0.45 percent of the content of the abstracts and 3.4 percent in 1978. Counting *family studies* and using the same assumptions, one finds these *comprise about 3.5 percent of the abstracts content in 1970 and about 1.7 percent in 1978.*

The critical question is, what proportion of drug abuse-related studies are family studies? (I used a broad definition of the latter: any reference to parents, children's attitudes thereto, etc.) In 1970 3 percent of the abstract index entries allowed inference of a family component in the article; in 1978 only 1.1 percent did. In absolute numbers, in 1970 there were 3 obvious drug abuse and family articles, in half of 1978, 8, or extrapolating to the whole of 1978, 16. There appears to be, then, an absolute increase in family studies, but at a rate of growth much less than the drug abuse field itself (yet greater in the drug field than in nondrug-related family studies).

Entries in the abstracts do not embrace all of the literature. Certainly my method is error prone, with no study of inter judge reliability, no

validating search of the original articles, no test of other points on my presumed straight-line curve between 1970 and 1978. Yet if we look at a comprehensive literature search, Stanton's (1978c) bibliography which includes clinical case studies, military monographs, and present papers, all likely to be missing from the abstracts, there are, from 1951 to 1978, but 370 entries, most from the 1970s. That is more than double a guess derived from my key word abstract search.

Another test comes from Steinglass's (1976) review of family treatment in alcoholism: from 1950 to 1975 his complete bibliography contains 46 articles, less than two per year. Janzen's (1977) review cites 52 articles from 1942 to 1977, or 1.5 per year. Most, of course, are recent. Whether my error factor is 100 percent or 200 percent vis-a-vis the total extant literature, the impression of but a few studies and a decreasing proportion of family studies in the drug abuse field is not proven false. An additional impression, gained only by a scan of titles plus my own reading, is that most studies that do exist are not controlled evaluations of the impact of family-oriented prevention or treatment.

If family studies are a minor component in drug abuse work, and a proportionately decreasing one, why may that be so? There are several possible "logical" reasons which, if rejected, lead to other than "logical," i.e., research-based ones. (1) Perhaps the family has been demonstrated by heartily convincing evidence to play no role in drug abuse (or alcoholism). Were that so, investigators would not pursue the inconsequential. (2) Perhaps the family factors have been implicated in etiology or treatment, but with such a low contribution to overall variance—or with such poor showing in comparative outcome evaluations—that the wise research workers, with empiricism their guide, look for greener pastures. (3) It is possible that the reverse of this is true, that there is powerful evidence for family factors, but that the work has been so complete, so incontrovertible, including evaluation of intervention clinically in treatment, that there is simply nothing further to be learned. (4) Alternatively, it can be that so much else is known about drug abuse variables, as, for example, how to prevent or treat problems by focusing on other more promising lines of inquiry, from enkephalins to methadone to electrical acupuncture[2], that family research must take a back seat.

Demolishing the straw men is possible. Is there anyone who seriously believes that family factors have not been shown to be important?

The works on drug abuse of Stanton (1976, 1977a, 1978a,b,c, 1979)

[2]Patterson claims this procedure is both the perfect and the only treatment mode (M. Patterson, personal communication, 1978).

Stanton and Coleman (1979); Stanton and Todd (1976, 1979); Stanton et al. (1978); or of Hedberg and Campbell (1974) on alcoholism; or with reference to delinquency (where one presumes drug correlates) Klein et al. (1977), and Beal and Duckro (1977) constitute sufficient illustration that family treatment methods can work and, comparatively, may be superior to others for treating individuals with problems shown or presumed to be related to their consumption of psychoactive compounds. For further reviews offering that conclusion for alcoholism alone, see Stanton (1977b), Janzen (1977), and Steinglass (1976).

It is easy to become cynical about drug abuse treatments, since claims often outrun credulity, yet if one employs research standards as demanding as those of Sells and his colleagues (1975-1977) the conclusions moderate cynicism. The results show that addict treatments work, that what works varies with the person and setting, and that impact is on social behavior as well as drug consumption. These and other studies do not stimulate one to leap for joy because cures are being found, but do allow both an optimism about treatment per se and, simultaneously, skepticism about "one and only" methods, even endorphins, even acupuncture. Thus, at present, even if some family therapy claims appear to be exaggerated, when that therapy is put to reasonably designed test, the results show a respectable impact, i.e., family therapy with drug abusers also "works," at the very least as well—and with the same caveats (kind of population, setting, etc.)—as other therapies.

There are good empirical and theoretical reasons for clinical interventions aimed at the family yielding positive treatment outcomes. The reasons are that, beyond what we consider any doubt, family variables have been demonstrated to be related to—and we believe shown linked in a causal chain to the emergence of—both disapproved drug use and problems associated with drug use. There are by now dozens of studies yielding those conclusions. We have reviewed many of these through 1976 in our own pertinent family research first reported in *Students and Drugs* (1969), then in *Horatio Alger's Children* (1972), and most recently in *Drug Education: Results and Recommendations* (1976).

Consider the clinical findings in *Horatio Alger's Children*, these derived from independent ratings of videotapes by two clinicians in which intact families with youngsters showing low, middle, and high levels of disapproved drug use interacted over several hours in "natural" experimental settings. A cast of genuine people—a priest, a narcotics officer, a young hippie girl, and a clinician—raised issues or presented challenges bearing on matters of eating, sharing, sex, morals, discipline, limits, and the like. I quote from the family dynamics chapters (pp. 283, 284) at that point where we sought to in-

tegrate the data from our large-scale study of families (one relying on standard interview, rating, and home observation measures) with intensive videotaped clinical interaction measures.

> ...that which emerged from the large-scale observations as traditionalism and respect for God and country among low-risk families is seen in the clinical study as part of a profound transgenerational pride in family—a primary affection and respect for family authority, which goes back to grandfather and the ancestors. What was reported in the larger study as greater satisfaction and lesser strife in the low-risk families came to be understood as part of a pattern of joyful and affectionate being together aided by tolerant and humorous ways for handling conflict. In contrast, in the larger study, high-risk families were found to be permissive and quarrelsome. In the clinical study it became evident that these characteristics reflected neurosis and psychopathology, insecurity and selfishness. In the same way, the homogeneity of views among low-risk parents and children in the broader study was traced to clarity of communication and the loving, authoritative, and family-centeredness of childrearing revealed by the clinical study. What was demonstrated statistically in the broader study as self-centeredness expressed in the pursuit of self-realization and pleasure among high-risk youngsters can be linked, now that clinical insights are available, to precisely the same attitudes in the parents, the same emphasis on personal goals rather than civic and social ones, the same preoccupation with a transient self, rather than permanent traditional values. Further, the vulnerability of high-risk youngsters to peer influences which carry them far in the exercise of liberty can be traced psychodynamically to the absence of the family as the center of emotional gravity from which all the most significant influences issue. In contrast, the warmth of low-risk families attracts and converts strangers, bringing children from other families under the sway of self-confident parents and children. It is also the case that the heterogeneity, discord, antagonism, and rebellion which was evident in high-risk youngsters seen in the large-scale study can be tied clinically to the relative absence of love, charity, humor, respect, tolerance, confidence, and joy in their families.
>
> The foregoing are but a few summary illustrations. The point is that the surface of the family, as measured by statistics on truancy, drug use, or what have you, is but a reflection of the family interior. When extreme families are studied intensively, statistical differences take on greater meaning. In the excellent families, the inner joy and strength are visibly expressed in harmony and happy adjustment. In the troubled or pathological families, pain and chaos may take a variety of forms, all of which visibly reflect disharmony, discontent, and a search for elusive meanings and gratifications. Risk-taking drug use by youngsters is to be seen in this light.

In our study of the impact of drug education (1976) we included a partial replication of the first study, partial in that different population samples, shorter observations, and mother-only contact was made. The findings were (pp. 121-123):

> Our inference from the items was that the parents of abstainers, compared with parents of high drug level children, were more religious, enjoyed greater marital stability and agreement, used fewer drugs, placed greater emphasis on child rearing, work, duty, discipline, and love of parents, supervised their children more closely, were more conventional, and opposed unsanctioned drug use. The higher drug use level children were, on the other hand, more often characterized as curious and adventuresome and their parents appear to value freedom, flexibility, and independence in the child....

> ...A second analysis of family features compared seventy stable with thirty-three extreme drug-using children, again from the family substudy total of 235 mothers and fathers. Except for school grade, the variables which discriminated these two groups were different than those distinguishing abstainers from high-level users. This suggests that subgroups of children that are defined differently by rather refined measures of drug use are, in fact, different in family background....
>
> ...The discriminating items suggest that the families of extreme drug-using children show more alcohol and tranquilizer use (but not more sleeping aids), that parents disagree more on child rearing practices bearing on the child's leisure time, drug use, and choice of friends, that an early "trouble" variable in infancy may exist, and that a sociopolitical stance which is antidemocratic may be present. The highest-ranked discriminator is the mother's rating of her child's overall interest in unsanctioned drugs; ...mothers' judgments of their children's drug propensities are likely to be correct.
>
> For the most part, these themes, as we infer them from the discriminating items, are similar to the results of our early, more detailed and intensive family study reported in *Horatio Alger's Children*. ...We must not, however, expect too simple a formulation to link family influences to different levels and patterns of children's drug use. ...We do, nevertheless, propose that a variety of family features are influential on that drug use. Be that so, then educational intervention is aimed at behavior which has been set in motion by forces at work earlier in life than school attendance and most likely operating outside the school, i.e., in the home itself. Drug educators should keep the importance of parents in mind.

From these findings, representing not only 7 years of direct research but the earlier work of our program beginning in 1962, I derive my convictions. I believe straw men (1), (2), and (3) are demolished. Family factors are important in drug abuse etiology. Family-oriented treatment can work. Family studies are not high-risk, low-yield research endeavors, nor have final truths been pronounced such that no further work needs doing. Consider, for instance, the area of parent education as part of prevention. Argument (4), that family work is simply less important than other matters, is, on the other hand, incapable of demolition, for it is obvious on its face by the choice of other topics by about 99 percent of drug abuse research workers.

What "is" need not be what is best, although by definition a conservative must needs disagree. For example, what "is" in NIDA research policy is now mostly pharmacology, for I am advised that about 80 percent of all basic research funding goes into medical-biological grants, the lion's share of this in the endorphin area. Yet endorphins—as prevention and cure, as opposed to exciting basic pharmacology—have already proven a hope too soon, and probably too much, or at least so concluded the RAUS[3] NIDA program review conference of June 1978. With a limited budget, the NIDA emphasis has meant very little money for other than molecular biological studies. Has that choice been entirely rational, and, conversely, has the disinterest in family studies

[3]Research Analysis and Utilization System.

been rational, too? I think not, and in thinking not one comes to the problem of fashion in research policy, to "resistances" (I use the psycholanalytic term), and to matters of cultural values, of which status is no mean element.

Consider endorphins first. One thinks of brilliant workers, exciting discoveries, the promise of "basic" prevention and treatment arising from molecular pharmacology, that done by "real" scientists and genuine "doctors," that is, people in white coats in typical laboratories in authentic medical settings. That has not been simply good hard science, which no one denies, but it is also fashionably reductionist, defensible as "real science" to legislators, and sufficiently exotic to challenge public as well as scientific imaginations. It was an excellent choice for NIDA policy except that it was, if the RAUS conference conclusions were correct, overly simplified and overly optimistic. That this is now seen as an impractical emphasis suggests more than logic at work; as I have implied, the choice represented the current culture of government science research: medical, prestigious, reductionist, hard, molecular. Thank goodness the wrong choice has been intellectually exciting, and as basic science, extremely fruitful, for being "wrong" in research funding is impossible, except for the practical science policy manager who seeks cures more than knowledge. That safely practical goal may itself be erroneous since few policymakers have the gift of assuring research outcomes by management objective.

So much for cultural values accounting in part for what is. What about that which is almost not, family research?

American social science, including much that is psychological and sociological research, is influenced by the culture of which it is a part more than it influences that culture. Fashion in research is more than likely to follow rather than lead public change. "Black studies" came after (with a few brave and significant exceptions) the 1950s when majority America finally decided to extend democracy. Women's studies, now popular, followed popular changes in values as to women's role and status. NIDA itself grew out of changes in America's drug-use habits and worries about illicit drug meanings and effects. As an illustration, the most widespread and expensive drug program going (we estimate half a billion dollars a year paid by local school districts) is in public school education; it is neither initiated by, paid for, guided, nor (with rare exception) studied by NIDA or its contractors and grantees. The most constant and intensive drug abuse prevention "program" going is in the daily life of the American family. NIDA has paid out but a tiny fraction of its overall budget to examine or improve this process. Indeed, the research in *Horatio Alger's Children* was supported by the Bureau of Narcotics and Dangerous Drugs. NIDA, just forming, appeared uninterested.

Insofar as either public ideas lead the social sciences, or the two are interwoven in the same cultural matrix, themes in American life will affect what researchers prefer and do. Insofar as a cultural theme may have within it inherent error, as tested against an empirical standard, the research choice will be biased against longer term success. On the other hand, when the test is circular, a value in search of itself via experimentation, consonance is the inevitable outcome. My concern is with the former, for insofar as influences may exist that are denied or relegated because they may be adverse to or tangential to mainstream thought, then the search for truth itself—or Platonic approximations of this ideal—is slowed. "Relevancy", then, by this idealistic and scientific standard, may be wrong.

What are the components in the American social sciences that are relevant and, therefore, biased?

- Environmentalism is one. Man is what his environment makes him. Any child, given equal opportunity, can be president. All, under equal circumstances, emerge as equals, with sameness a good in itself, for Americans, while tolerant, fear difference.
- Consider immediacy. Change, when desirable, should occur rapidly. Do that by changing the immediate environment immediately.
- Consider control. Whatever one wants to accomplish can be done. Paradise is not attained on earth only because those with power or skills have failed to take the technological or legal steps to assure it. When there is neither cure nor reform, one must suspect intentional self-interested obstructionalism.
- Consider peer group primacy. The American is a member of a collective of equals which through its norms governs not only his conduct but becomes his personality, George Herbert Mead's reflecting process. There is no inner self, only accumulated reflections, no gyroscope but litmus paper, no inertia but adaptation.
- Consider flexibility rather than commitment. This is eminently modern; people make love and babies, not marriages. We see live-in couples, single parents, millions of teenage illegitimate mothers; a relativistic and accommodating society favors ease as well as change. The morality of commitment to the institution of the family is suspect; it interferes with flexibility, selfishness, exploitation. The family qua institution is a disciplining, obligating bore.

Enough? Where any of these themes are prevalent, they counsel against family research and therapy. What do we know about families that warns us of that? Families are not entirely environmental; they transmit heredity. Families are not quick-change artists; the family is

an enduring institution whose styles and values are transgenerational. What children learn from their parents affects them all of their lives. The family anchors habits. The family may control, but it is not controllable. It is private, and privacy, while guarded legally, is essentially un-American. The sound family rejects external rule, is skeptical of childrearing by governmental agencies, takes responsibility within itself. Unsound families are preferred for they take no controlling responsibilities and project blame. Agencies flock to them as they to agencies.

Further, the family is not a peer group; sound families are not collections of equals. Good parents are not their children's friends, for power is differentially allocated on grounds of age, wisdom, strength, ability, and role appropriateness. Good families produce strong characters who may elect to ignore, even disdain, peers. Matured personalities contain evolved morality—ask Thomas Moore or Piaget. Morality sets immediate limits on adaptability. Relativity, flexibility may be bad, not good; the judgment requires complex consideration. Within the sound family, selfishness is anathema, immediate gratification an impossible demand, one not even made. Convenience and sex are subordinated to forecasts of consequences in which beloved others figure. For those so reared, the family is not dead and it is certainly not, as concept or experience, a bore.

The family is, essentially, an historical institution in which, ahistorically, the accumulated experiences are part of the individual's life space. That history, whether of grandfather or yesterday, is compelling. It is a traditional institution that, along with the church, is the traditional formal seat of intimate moral and interpersonal power in a society, even in our society. In a society eager for the quick fix through either technology, law, social policy, or scream therapy (Does methadone qualify? I think so.), or, aptly enough, through drug use itself, the family does not conform to the research-by-objective social planner's mood for agreeable, accessible interventions. It is no accident that the other inaccessible carrier of morals and lifestyles, the church (discounting the "with it" Mass) and its controlled mysticism, has aroused no interest whatsoever among drug abuse researchers, not even those few who do recognize that spiritual experiences—from gentleness to ecstacy to God—loom large (though suspect) in the religious phenomenology of drug misuse. Ask William James.

There is further incompatibility between the family and those moderns who are social scientists (a group, by the way, that scores notably high on liberalism compared to other professions) or social planners. The family sees itself as influenced by, arising from, springs other than those in the modernist's book; and it may insist to the observer that he recognize these. It views itself—when it is sound—in

terms of luck, destiny, and heredity. Free will, i.e., responsibility, is also strongly embraced and while determinism is acknowledged—what could be more dramatic an affirmation than conscious, energetic "parenting?"—the environmental determinism of the social sciences is held an insufficient accounting for what transpires. In the family, "miracles" still occur.

More than any other phrase we heard from those parents our work characterized clinically as being healthy, wholesome families was the expression, "We're lucky." Such families never have destiny or accident, nor even the mystery of grace, out of mind. Nor do they discount heredity. "Blood is thicker than . . ." "The spitting image of . . ." "I see my mother whenever I look at . . .". There are no genetic proofs here but consciousness of a generational membership, of subordinated belonging individualism. Appearances, strengths, tempo, frailty convince them; so do love and identification. Long denied by American and Soviet environmentalism, one begins now to see in research findings that the evident, and with respect to drug and delinquency vulnerabilities perhaps the hidden, aspects of family consciousness are not fantasies.

Of course, neither destiny, nor genetics, nor morals rule out the family as an environmental force. Beginning with embryological field theory it is generally granted that development is a product of heredity-environment interaction. But a dogmatic investigator—or even a flexible young one who wants promotion—knows better than to expose himself to a research arena that, knowledge aforehand, challenges doctrine and is not at the leading edge.

These, then, are the resistances, the cultural themes that pervade that mirror of progressive culture which is the social sciences. Many practitioners resist being "social scientists," for the term arouses little respect among the citizenry. "Social philosophy"—which much of it is—is rejected. The field has long been searching for a name as prestigious as its aspirations: "policy sciences" was tried on but it did not fit; "behavioral science" was respectable as far as it went, but its aura was not sufficient. Specialty terms do better, being more exotic—"psychologist," for example—or arcane subspecialities in turn—"psychopharmacologist," such terms too far removed from ordinary ken to clear away the intended mysteries. What romance is there in being a student of something as old-fashioned, ubiquitous, commonsensical as family?

Family work is low-status work, whether it is research or treatment, or even that great rarity in that field, research on treatment. Consider the academic origins of those who are acknowledged greats in the family field: Weakland (M.A. only, that in chemistry), Haley (M.A. only), Satir (M.A. only). Bateson has a Ph.D. but in anthropology, where

family, i.e., kinship, is respectable. John Elderkin Bell's doctorate is in education. Jackson and Ackerman were M.D.s as is Bowen, but all three can be considered notorious mavericks. Blum and Stanton are latecomers and both respectable, but Blum, as some readers of this paper may conclude, may not be trustworthy. Given the career lines of the outstanding workers, Bateson, Weakland et al., Merton's delinquent opportunity thesis seems applicable; those of disadvantaged origins necessarily denied access to legitimate routes for achievement take a delinquent path. For the psychological sciences, the "poor" origins are reflected in the missing collegial approval for their preferred work arena. The family therapist's delinquency has been, like other delinquency—and like drug abuse—pursuing the disapproved in spite of the standards of his peers.

The outcomes of investment in the family have been good, just as strong character and disciplined creativity come out of those good families that prevent their offspring from becoming solely the creatures of popular values. We can point to good outcomes, not yet acceptable to our peers, and for reasons other than empirical. That is where we stand. It is also where we as a field are failing through lack of interest in family work. Perhaps the opportunity for change is at hand; I take NIDA's commissioning of this paper as reason for optimism.

It is time to learn more about how the family prevents most youngsters from becoming drug-using problems, to test how to reach and help less wise parents do better at this, and to experiment with improvements in family therapy. It is also important to learn how to get social scientists to accommodate to the fact that the family is not boring, nor inconsequential, nor dying. Excelsior!

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11. Drug Use and Families — In the Context of Twentieth Century Science

Edgar H. Auerswald, M.D.

I have come to the conclusion that, if our country is serious in its apparent wish to attack the phenomenon of drug abuse, the way to do so is *not* to develop drug abuse programs, but instead to develop a system that will support and foster family life. The following is a presentation of how I have come to this conclusion.

In the last couple of decades an idea has been lurking around the edges of the collective American consciousness. It began to permeate our thoughts, I suspect, when we first gazed at the image of our earth from the vantage point of our moon via the television screen. It has been given substance by the recent belated popularization of the model of our universe that has emerged from the revolution in the physical sciences that took place very early in this century. The idea is that each of us constructs his or her own "reality," and that, if such be the case, we have choices as to what versions of "reality" we wish to construct. In the cybernetic universe, this idea appears to be true.

Such an idea is, to say the least, liberating, but it poses some serious problems. To a large extent, our thoughts control our social behavior, and our social behavior determines which of us is accepted or rejected by the social and cultural systems we inhabit. In fact, we have a word for the individual who constructs his private view of reality and behaves, as a result, without regard for the rules of the predominant collective sociocultural view. The word is "crazy."

Luckily, the human animal has evolved in such a way that thinking can take place without automatic action, so it is possible for each of us to engage in the construction of an infinite variety of alternative realities in our thoughts, and yet choose our actions in a manner that

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will maintain our sociocultural membership. We have a word for this exercise, too. The word is "creativity."

We also have evolved a method of controlling our creativity by tying it to that which our biological senses, and, lately, the technological extensions of our senses, perceive *collectively*. Again, we have a word for this collective endeavor. The word is "science."

Twentieth century science, as we all know, is an exciting endeavor. The excitement, I believe, is that which accompanies birth. The single reality of 19th century Newtonian science gave birth to a new collective reality, a mutation, beginning with Einsteinian relativity and quantum physics. This new science has called attention to a way to think collectively about ourselves in the universe which to date we have barely begun to utilize. Nevertheless, we have presented ourselves with the opportunity to identify phenomena *we could not even perceive* in our previous single view of reality (black holes, for example), and to re-examine *all* of the phenomena with which we have been previously concerned. If we can seize upon this opportunity, we *truly may* be present at the dawning of a new age in which we may well find solutions to the age-old problems that have plagued our species—maybe even war, for example. It does seem imperative that we begin this rethinking process posthaste, since we do seem to have reached the point in evolution in which our old version of reality may well lead us to extinction.

It is difficult to settle on terms to denote the two ways of perceiving reality. There is no generally accepted language that is applicable. Neither Newton nor Einstein invented them. Newton thought within one, and Einstein thought within both. In previous writings I have referred to the version used by Newton as the "interdisciplinary" approach, or "Western epistemology," and to the alternative used by Einstein as the "ecological systems approach" or "ecological epistemology." This time around, however, since I want to emphasize that both reality views are rooted in science, I will in this paper call the two versions "Newtonian" and "Einsteinian."

I must also state, before I continue, that I have been trying for 17 clock years to program my biocomputer to perceive and think in Einsteinian Reality, in addition to and separate from Newtonian Reality, in which I have been thoroughly programmed to think from birth. I have not yet been fully successful in this endeavor, largely because there is not yet a language to think in that is thoroughly based in Einsteinian Reality. But, I am arrogant enough to think that I have been successful enough to write this paper.

In the space alloted to this article, I cannot really develop the differences between thinking within the two science-based realities in

any detail. However, since epistemologists (those who are thinking about *how* we know) generally agree that the alternate realities begin with concepts of space and time, I can briefly describe some of the differences in these concepts.

In Newtonian reality, space is conceived of as a vacuum filled with things, arranged in hierarchies, and time as horizontal linear movement at a steady rate as measured by clocks. Energy is that which moves things through space during linear clock time. Processes are thought of and described separately from things and are recorded in clock time. Data collection consists of describing, classifying, counting (using numbers), and qualitative weighting of things, again using numbers or hierarchical position. Methods of data analysis are aimed at cause-effect relationships arrived at by linear induction and/or deduction. The digital computer performs many of these functions more efficiently than the biocomputer, which, however, must provide programming.

In Einsteinian reality, space and time are not separated. The universe consists of expanding, contracting, interrelated phenomena occurring in space-time. Data (so far, at least) consist of descriptions of phenomenological relationships. Since the languages that evolved from Greek and Latin all reflect Newtonian reality, such descriptions in these languages are often in the form of a story, analogy, or parable. Classification is transient, heuristic, and based on similarity, difference, and novelty of recursive phenomena. Probability is used in place of counting. The method of data analysis is also relational, and data are connected and contextualized by transduction. The biocomputer performs most of these functions more efficiently than the digital computer, although the analog computer offers promise, and the digital computer can be used adjunctively.

I wish herein to present some data and its analysis. Since I have written of the two realities, I should refer to data collected within both. Luckily, I am spared the need of presenting data collected within Newtonian reality. I can simply refer the reader to, I would guess, 99 percent of the research literature published separately on the topics of drug abuse and the family. In this literature, the authors either present and argue for the validity and usefulness of one paradigm or another, all within Newtonian reality; they attempt to define what kind of thing "drug abuse" or a "family" is, or they try to assess what processes in clock time determine the nature of or can change either of these things. Each of these kinds of paper fits neatly into the space and time concepts of Newtonian reality.

The following, then, are data extracted from my own biocomputer, stored, presented, and analyzed within Einsteinian reality.

New Haven Railroad/1965-1971

I was commuting to work in New York from home in Connecticut. I became friendly with a number of advertising executives who worked on Madison Avenue. They all drank two or three martinis or scotch highballs at lunch, and managed to down a similar number while waiting for and riding the train. Their talk consisted almost entirely of complaints about the competitive rigors of Madison Avenue and marriage and family problems.

The cast of characters in my train group diminished gradually. Most who left reported that they had split from their wives and were moving back to the city. Twice, however, the report was different. Each of these men announced that he was leaving his job to "save my family." One went to work at a boatyard in eastern Long Island. The other bought an apple farm in upstate New York. I had occasion later to drop in on both these men. Except for an occasional cocktail before dinner or at a party, neither was using alcohol. Each reported that his family was thriving.

New York, New York/1967-1969

A good friend of mine became friends with a young man from Puerto Rico who was engaged in three interlocking activities. He was a college student. He was a leader in the militant Puerto Rican civil rights group known as the Young Lords. He was a user of heroin. A few months after he and my friend met, in that amazing year of 1968, the young man decided to leave the hectic life he was leading to seek a more peaceful clime. Especially, he wanted to get off heroin. A couple of months after leaving New York he wrote to my friend. He reported that he was on an Indian reservation in New Mexico where he had found a family and had kicked the habit. His note ended rather wistfully, "I think I am happy," he wrote.

No more than 6 months later he appeared at my friend's door in New York one night. "I decided to go back on heroin, so I could get my degree," he announced. He did get his degree, after which he returned to work on his father's ranch in Puerto Rico. He stopped taking heroin on the day he left New York. "I don't need it when I'm home," he wrote.

New York, New York/1970

I was developing an applied behavioral science program in an OEO[1]-funded neighborhood health center. The program trained and

[1]U.S. Office of Economic Opportunity.

supplied supervisory consultation to multidisciplinary teams assigned to work with medical staff in combined family health teams, each of which served a census tract.

One day a social worker from one of the teams asked for consultation. She brought the following story to me: One of her assignments was to work as liaison person to a large public housing project in the census tract served by her team. In this capacity, she had been trying to get a number of "welfare mother" clients into the project. One day, as part of inservice training, she attended a conference at a nearby methadone maintenance program. A client of the methadone program was at the conference to discuss his heroin addiction and his treatment. He had an unusual last name, which the social worker noted was the same as that of one of her "welfare mother" clients, who had reported that her husband had abandoned her. The social worker asked the man if he was married, and his reply was "no." However, she subsequently saw him emerge from the apartment building in which her client lived.

She then questioned her client about this, and with some reluctance the woman told her the following story: Her husband, an unskilled black man, had never been able to find a job that paid sufficient salary to support his family, especially since the family grew rapidly with the birth of four children in 6 years. When, after the birth of the second child, the mother applied for welfare, the couple discovered that the sum total of the father's salary and the payments for which the mother was eligible, limited as they were by the fact of the father's employment, were still insufficient to pay the bills. They discovered that other women with a similar number of children received more money when there was no father in the home. The father decided to move out of the home, so that the mother could claim to the welfare department that she had been abandoned. Her payments would then increase, and the sum total of her welfare income and his salary would be more sufficient. Although the father spent many nights at home, he and his wife lived in fear that they would be discovered by one of the spot checks made by welfare workers for this purpose.

In order to save money the father lived in an abandoned tenement house where several other single men also lived. Several of the men who lived there were junkies. The father began experimenting with heroin and quickly developed a habit. After a hectic year, difficult for both the father and the family, he had entered the methadone maintenance program, where he had also received help in finding a better-paying job. Upon hearing this story, the social worker suspected that there must be other such families in her housing project. She began checking the names of men in the methadone program against those of women living with children in the housing development. Eventually,

she traced 11 families with a similar story. She did not want to blow the whistle on the adaptive conspiracy in these families, and she had come to me for consultation in the hope that I would be able to help her decide what to do next, if anything.

The only suggestion I could think of was to convene a meeting with all of the couples involved for the purpose of exploring whether there was anything that could be done. The meeting turned out to be very hard to organize, but about 3 months later the group convened one evening in the waiting room of our neighborhood health center, the only space we could find large enough to hold the whole mob. Among the many things we learned that night was that none of the men had used heroin prior to leaving the home. All present, husbands and wives, expressed their wish to be able to live together again. All they needed was a way to acquire an income that was sufficient to support them. However, the wives were afraid their welfare workers would discover that they were still seeing their men, and the men were afraid that if they dropped out of the methadone program, they might lose their jobs. They agreed, however, to meet with the welfare workers and the methadone maintenance program staff.

At this next meeting the situation was presented to these "helpers." Together, we cooked up an enlarged conspiracy. The two welfare workers present agreed not to report the presence of the men in the home. The methadone program staff agreed to support the men in keeping their jobs, even though they would formally leave the program. The conspiracy was carried out, and a year later all but two of the men had been drug free since returning home. The two who had gone back to drugs did so after they had left home because of marital difficulties.

Maui, Hawaii/1971-1974

Upon moving from New York to the island of Maui, I found an army of young refugees, many of them originally from New York, who had split to the sun. They were desperately trying to form families, despite constant harassment by local officials who wanted to deport these strange Americans from island America to mainland America. For the most part, their efforts to form families failed, but not entirely.

The families that survived shared certain characteristics. A prerequisite for survival was the achievement of economic autonomy. Given this ingredient, those groups that achieved some stability made abstinence from drugs and attitudes of noncompetitive mutual support a rule of membership. Additional stability was achieved when the group collected around some organized transcendental belief system, Zen

Buddhism, born-again Christianity, etc., you name it. The *most* stable groups re-emphasized the importance of the "nuclear family" in the context of a volunteer extended family.

New York, New York/1964

I was practicing psychoanalysis in New York City. One of the people I was working with was a successful woman author who wrote romantic novels. The main women characters in her novels, like their creator, all had become out of touch with their families in one way or another. They were sophisticated drifters, jet set ghosts, who used a lot of drugs.

During her analysis there was a 6-month period during which the author became stuck in her writing. She could not find a resolution for the plot of her current novel. She began drinking heavily and experimenting with other drugs. In her sessions she repetitively poured out a description of her family, a large network of Tennessee hill people, farmers and Baptist fundamentalists. They considered artists sinful. When her first book had been published, instead of being happy for her, they had been appalled. She had not seen any of them since.

One day she arrived for a session a half hour after she had taken LSD. I cancelled my other sessions and stayed with her. During her trip she hallucinated a bright and colorful sunlit place where she was surrounded by warm people, although she herself felt cold. She began to shiver. I brought her a blanket and held her hand. In her hallucination I became one of the people who moved close around her and made her warm.

The following day she left a message for me cancelling her sessions for the next two weeks. When she returned I discovered that she had gone to the hills to make peace with her family. She had discovered that they did not hate her. They were afraid of her, because they could not understand her talent. The Sunday before she left the whole family network had convened to celebrate her return.

She finished her novel in one week. The plot resolution had the heroine return to her family. Except for an occasional drink or toke at a party, she stopped using drugs entirely. A year later she married and adopted what was the first of three children.

New York, New York/1965-1971

While working on the Lower East Side of New York, one of my activities was to attempt to extract beleaguered "flower children" from the rip-offs and violence that had turned their dreams of love sour. I was

herding these youngsters into the same room with their estranged parents whenever I could arrange it. More often than not the fathers in these families were like the advertising men on my train. They had little time for their children. They were too busy climbing competitive ladders and protecting their hard-earned status. They all stated that they carried on these activities for the sake of their families. They were angry and dismayed by their wives' complaints of neglect, and their children's lack of appreciation.

These estranged people were all on drugs. The father was on booze, the youngsters on psychedelics and downers, and, most of the time, mother was also dulling her despair and anxiety with some chemical. These families were tough to deal with, but many of them had reached rock bottom, and, like alcoholics, they were sometimes willing to make major changes. When they did, the chemicals disappeared.

Through all of this, in and among the families in turmoil, wandered the psychedelically burned-out isolates and the junkies from the world of poverty, familyless and lost, and the rip-off artists, the exploiters, also familyless.

Greenwich, Connecticut/1965-1970

I lived next door to the family of a salesman who was on the road from Monday to Friday night. His wife, a bright and attractive woman, spent her days taking care of two very young children. She dropped in on my wife daily to talk of her frustrations and her symptoms. When we first met she was taking barbiturates prescribed by her doctor to help her with anxiety attacks and insomnia. Valium then appeared on the scene, and her doctor changed her drug. When she ran out of pills, she nipped brandy. On weekends she and her husband drank noticeable amounts of booze together.

One day, in tears, she reported a crisis. Her husband had lost his job. Within a few weeks, however, he began working for a friend who owned a lumber business. He could walk to work, and came home for lunch. At first, because of considerable reduction in income, he spoke of his new job as "temporary." A year later, however, he no longer considered his job "temporary." His wife was symptom free without drugs.

USA/1959-Present

In all the time that I have spent working with and observing families, I cannot recall a single, openly communicating, mutually respecting, well-organized, lovingly close family in which an actively participating member had a serious and lasting drug habit—transient experimenta-

tion, occasional booze or pot, yes, but disabling and lasting drug use, no.

Now, for the analysis of the above biocomputer data. Two conclusions emerge. One conclusion that seems inescapable is that the phenomena of the family and of consistent psychoactive drug use do not mix at all. They do not even form a stable emulsion. Where one thrives, the other does not. Another conclusion is that the phenomena of the family and of highly competitive, time-consuming striving for upward socioeconomic mobility do not mix, either, if the latter dominates the former. This conclusion may only be valid for those families who lack day-to-day contact with extended family or highly supportive community networks. Since more and more families are in this state these days, the conclusion has some significance.

Thus, I come to the conclusion I stated at the beginning of this paper. The way to diminish the use of psychoactive chemicals within our society, *in Einsteinian reality*, is not to develop more drug programs, but rather to introduce measures that support family life.

If I continue to think within Einsteinian reality, it becomes apparent that our current social organization that grew within Newtonian reality is doing just the opposite—creating conditions that fragment families and their support systems, and leaving vacuums that become filled with chemicals, to the extent that we are evolving a technology and an industry to supply them. We cannot legislate these chemicals out of our society because, it seems, we need them as stabilizers for our current social system. What then can we do now?

Before offering an answer to this question, I must make another point. I could, within Einsteinian reality, use what I have written above to write a paper on the interactive relationship between the phenomena of the family and most of those phenomena we classify as "functional mental illnesses" and "emotional disorder." I would simply extract and record a different batch of descriptive data, taking care to demonstrate that biochemical changes are part of the phenomena so as to avoid stimulating the mind-body controversy of Newtonian reality as much as possible. The analysis of the data would be very similar, if not the same, and the paper, up to this paragraph, would lead to the same question. What can we do now?

Well, we *could* stop building large high-rise apartment buildings that seem inevitably to lead to family isolation. We *could* develop a plan to use our technology to decentralize our means of production with emphasis on small and local labor-intensive industry which would keep fathers close to home and release them from the lost hours spent on commuting trains and super highways. We *could* modify our educational system to deemphasize competitive ladder climbing, and emphasize self-realization in the context of what might be called

"family-realization." We *could* release families from the fragmenting rigidities of laws that line family members up on opposite sides of adversary procedures. We *could* develop "helping" systems that define their tasks as serving families, not primarily individuals, and refrain from labeling people with functional quasi-medical diagnostic labels that imply that the primary site of the problem is inside their skin. There are many other such changes we *could* make.

As steps closer to home, we *could* set aside resources now going to "drug programs" that ignore families or consider work with families as "ancillary" to the primary focus on individually focused "treatment," one at a time or in groups. And, we *could* set aside, say, half the resources now going into community mental health centers that serve those who "have" functional mental illnesses, emotional disorders, or drug abuse problems. These combined resources *could* be used to support a network of in-community teams, trained to think in both realities, whose *primary* task would be to undo crises in families and construct family support networks using current "helping" systems and the unorganized potentials that exist in every community.

I do not think we *will* do any of these things in the near future, however. The reason is that there are not yet enough people whose biocomputers are programmed to think within Einsteinian reality. These moves do not "make sense" in Newtonian reality. In fact, Newtonian thinkers call them "unrealistic," which they are, of course—in Newtonian reality. Thus, the collective mind of our society has probably not yet evolved to a point where the above suggestions comprise a feasible course of action. There is, however, widespread dissatisfaction with the current conditions of life in Newtonian reality, and there is evidence of a growing core of people whose biocomputers are developing Einsteinian programs. I think the balance will eventually shift—but not yet. In the meantime, there are some actions that we can take.

Those of us who work as clinicians can teach families that while they must live in a society that is constructed within Newtonian reality, they need not be *owned* by it. We can, as individuals, in our day-to-day lives, point out the absurdities so patently visible in the behavior of the fixed hierarchies of Newtonian reality to all who will listen; that is, that the inhabitants of such hierarchies spend much of their time playing "king on the mountain" and, together, protecting the boundaries of their particular hierarchy, using the techniques of overt or covert cold war.

And, we can become sales people for the notion that science has provided us with a way to think that offers the possibility that we can get past the paradoxes that threaten our survival. We can sell Einsteinian reality as a highly useful human biocomputer program—which is, of course, what I am trying to do with this paper.

12. Report of a Workshop on Reinforcing the Family System as the Major Resource in the Primary Prevention of Drug Abuse

Barbara Gray Ellis, M.S.S., M.P.H.

INTRODUCTION

There is the potential in the family system to foster either constructive or destructive coping styles among the members. This paper[1] will describe some family-centered measures that will promote healthy, constructive, coping behaviors. The constructive and healthy aspects of the adaptive strivings referred to as "coping" are emphasized here because drug-abusing behavior is seen by some as reflecting failed coping efforts that have unhealthy, destructive consequences.

Constructive coping styles have *generic* components and generic effects. It is probable that people who develop constructive coping skills do not, in general, become dependent on drugs or alcohol, do not become mentally ill, do not manifest delinquent behavior, and do not abuse children and/or spouse. In other words, with healthy coping mechanisms that are generic in scope and potential, they successfully negotiate life's predictable and unexpected stresses and crises without resorting to behavior that is destructive to self or others.

The charge to prevent drug abuse is interpreted as being *specific*.

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The policies, programs, objectives, and fiscal commitment of the National Institute on Drug Abuse (NIDA) are specific in intent—all directed toward incidence/prevalence reduction (prevention) of drug abuse. The "generic" and the "specific" represent two different perspectives from which to view dysfunctional behavior, and the differences between these perspectives produce conflicts and contradictions. There are constraints, for example, in mounting a program designed to promote personal wellbeing and competence in constructive coping—successful and healthy personal functioning—on the grounds that it is vague, "a nice idea," but too general. It suggests global dimensions; it is generic. It may be seen as "nondrug-related," and probably "nonproblem-related" and, as such, would have no constituency and no source of funds. Contradictory considerations such as these have their origins in, and are perpetuated by, the nature and objectives of the governmental legislative process that is geared to the specific, and manifests itself most strikingly in the proliferation of categorical programs. Thus, we have discrete legislation and appropriations for dealing with drug abuse, alcohol abuse, mental illness, juvenile delinquency, child abuse, and spouse abuse, to name a few instances of troubled behavior.

The people who set the direction of public policy and funding guidelines for dealing with dysfunctional behavior particularize the problem behavior but, at the same time, generally acknowledge the commonalities in many kinds of dysfunctional behavior. In some of the documents that reflect executive and congressional intent in the matter of drug-abusing behavior, for example, there is appreciation of the fact that drug abuse "occurs within a general behavioral context" (Strategy Council on Drug Abuse 1979, p. 28), and that programs designed to prevent one type of problem behavior will generally have impact on other behaviors as well. Alongside these observations, derived from generic assumptions, there is the contradictory mandate "that a *categorial*[1] emphasis on drug abuse must be maintained at all levels of government" (U.S. Congress 1979, p.20).

It is both desirable and possible to bridge discrepancies between the peculiarities of governmental policies and the realities of people striving to cope in real life situations. Certainly, seasoned mental health professionals approach specific problematic behavior from the generic perspective; yet they also recognize that there are specific, as well as generic, antecedents to and treatment strategies for each of the behaviors labeled as dysfunctional. A most promising development, in fact, is the emerging trend to acknowledge and identify the commonalities among the "addictive disorders." But the larger

[1]Emphasis supplied.

problem continues to be how to conceive of and express the generic ingredients of constructive coping in concepts and terms that are applicable to behaviors that are seen as specific.

In discussions in NIDA's Office of Program Development and Analysis (OPDA), we became intrigued with the supposition that the family, as a commonly experienced social system, has inherent and peculiar properties which, if fostered and enhanced, can become effective factors in the service of *learning healthy coping styles* and, thus, in the primary prevention of troubled behavior. We speculated about ways in which a Federal agency such as NIDA could promote the development of activities that would reinforce the family system as the major resource in the prevention of dysfunctional behavior, which would include, of course, drug-abusing behavior. This notion had the dimensions of a generic endeavor within a categorical organization. Moreover, it was comprised of at least two other controversial elements:

(1) The idea of "the family"—a fundamental experience whose essence tends to be obscured by its universality; ubiquitous to the point that it has become almost casually regarded; diversely defined; and

(2) The concept of "prevention"—multileveled; equivocally, variously, and ambiguously defined; fashionable but elusive "in the trade."

Moving on the conviction that these generic considerations were timely, we proceeded to seek the sense and guidance of people in the professional community. We communicated with a number of psychiatrists, psychologists, social workers, educators, and sociologists—all persons whose interest and expertise in family growth and development were well supported in the literature—asking the questions:

- Is the state of the art sufficiently sophisticated to enable theoreticians and practitioners in the field of family growth and development to design models for direct preventive work with families?
- What value would the implementation and utilization of such models have in the prevention of drug abuse?

In various ways most of the respondents to our inquiry were already engaged in direct preventive work with families, and in the primary prevention of drug-abusing and other self-destructive behaviors. Their work, however, had not been specifically conceptualized as drug abuse prevention, an entirely appropriate stance from the generic perspective but troublesome from the categorical point of view that is essential in the funding of research.

We concluded, therefore, that the field of human services is ripe for

the evolvement of primary level intervention methodologies with families. We reasoned that the theories, methods, and techniques applicable to primary prevention are not substantially different from those underpinning family therapy (tertiary intervention) or crisis intervention (secondary intervention). The key difference is that *primary intervention occurs at a different point in the unfolding family process.* The focus is on supporting and improving family abilities to foster constructive coping strategies among its members before problems appear. The further removed a family is from the "treatment," or tertiary end of the intervention continuum, the less ingrained the dysfunctional behavior patterns are, and the easier it is to maintain and support growth (Batty 1978). Thus, we proposed a working definition of generic primary prevention from the family perspective as preventive maintenance of healthy family functioning as a means of fostering healthy personal coping styles.

THE WORKSHOP AND THE PARTICIPANTS

OPDA invited a group of the respondents to a 2-day workshop in June 1978, with the aim of developing practice models that will facilitate families in accomplishing the task of nourishing and sustaining healthy coping capabilities of the members. Among their other activities, all participants were engaged in the practice of family therapy based on varying theoretical frameworks. The workshop participants are shown in the accompanying list.

Their broad assignment was to develop models of the practice of family-centered primary prevention that can be demonstrated and evaluated, and that have particular relevance to families who are, by definition, high risks for drug abuse. Moving from the generic to the specific, and basing the considerations on what we know about families who abuse drugs, we were seeking to identify and describe the nonremedial (as opposed to therapeutic or rehabilitative) measures with which we can intervene on the side of constructive coping, to the extent that we can favorably influence family development and prevent the genesis of future addictive behavior.

At the outset there was consensus that gearing up for primary level intervention with families will require a 180-degree turn in conceptualization, and in the redirection of resources. Tertiary intervention in the treatment of drug abuse (and other dysfunctional behavior) continues to be the area with the highest concentration of effort. Secondary intervention with families, which has been gaining support in recent years, is typically offered when the family is threatened with a crisis because a member has begun to experiment with drugs. Primary

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prevention of drug abuse, *as a mode of intervention with families*, is relatively undeveloped.

Two factors became recurring themes in the workshop deliberations: context and process. The contexts within which *problem* and *program* are viewed are critical determinants as to what the trouble is defined to be, and who will do what about it. Three contextual considerations are: the context in which problems arise; the context in which problems are responded to (programs); and the context in which problems are resolved. The context within which dysfunctional behavior emerges is generally the family system. The context that responds to the negative behavior is the community system, large or small. The context in which the problem behavior is resolved is the family system, strengthened and enhanced by the community system.

Process influences the accomplishment of the primary tasks of the family system: to provide for the stabilization of the adult members; and to produce autonomous children.[3] The process by which a family approaches and accomplishes these tasks is a crucial variable in the development of reliable coping skills. The process whereby the community system responds to troubled people at secondary and tertiary levels of intervention is of equal import in fostering healthy family functioning.

Participants worked in four subgroups, generating 60 pages of summarized proceedings.[4] The intent of this paper is to present some of the high points of the workshop proposals in such a way as to faithfully reflect the key elements of the practice models. Some of the ideas are novel; many of them are familiar but achieve some difference by being set into a different configuration. Each working group designed a model to facilitate primary prevention in work with families. Each was concerned with the generic aspects of prevention but, in addition, adapted to their product the specific antecedents and strategies relevant to drug-abusing behavior. The models are not discrete entities, of course; they reflect predictable overlap but blend together along a continuum of ideas that support the fostering of family competence in promoting coping skills.

The Models

The "family intervention model" and the "family education model" deal with somewhat differing methodologies and sites, but both aim to

[3] From remarks of Jerry M. Lewis, M.D., at Seminar on Family Issues and Drug Misuse and Dependence, National Institute on Drug Abuse, Rockville, MD., January 25, 1979.

[4] Taping, transcribing, and summarizing were done by Ann McGonigle, Boston Family Institute.

impart to families knowledge and sensitivity about family growth and development, and process. For the purposes of this report they are combined and will be discussed as the family intervention model. The "media model" proposes ways to exploit the potential of television in the service of education for and support of the requirements of real-life family coping, with suggested countermeasures to correct the prevailing television image of family life. The "ecological model"—also called the "systems linkage model"—reflects a rearrangement of the contexture of the community, and revisions in thinking on the part of the human services professions. It establishes an eminently suitable environment in which the other models can flourish naturally, and will be described first.

The Ecological or Systems Linkage Model

The group proposed, in general terms, a rearrangement of the elements of the system for delivery of human services that will facilitate *systems linkage*, and reconstitute the sense of connectedness of families to their communities or neighborhoods. The emphasis is on horizontal rather than vertical working relationships, and the rationale for such rearrangement of relationships suggests the changed context in which problems and programs are viewed.

The rationale derives from the realization that increasing specialization in our society has brought with it a form of social organization that is a vertical hierarchy. Decisions are made at the upper levels of the organization; information travels more rapidly downward than upward; and the entire organization is task oriented. Agencies that "deliver services" or "help" people are organized in this vertical manner along the same lines as companies that manufacture products. The functions of the helping organizations are so particularized that people receiving "help" must meet certain intake requirements. They must be unemployed to receive welfare; troubled and anxious to receive mental health services; and be classified as slow learners for special education programs. People who seek services must be willing to accept labels in these categories in order to have their needs met. Moreover, they must present themselves to a designated place at a designated time to get "help." If the help is not utilized in keeping with the expectations of the organization, the clients relapse or recidivate, and get recycled through the system for more of the same. Although this is a gross oversimplification of agencies and services, the helping system now in operation can be seen in this way. From the perspective of the systems linkage model, the vertical form of organization for the delivery of human services is itself dysfunctional and is a contributing factor to the pathology it is designed to alleviate.

Horizontal systems linkage becomes more than interdisciplinary delivery of services. The aim of the ecological model is the redefinition of social contexts. Redefinition will bring changes in—

- The organization that delivers service;
- The role of the professional;
- The use of space and time by the service deliverer and the service recipient; and
- Methods of evaluation and cost accounting.

The broad service goal of systems linkage is the realignment of societal units; realigning—

- Groups of individuals called a family, with
- Groups of families called a neighborhood/community, with
- Groups of organizations that help individuals, families, and communities.

The agency in the systems linkage scheme does not decide which societal units it will serve (intake policy), nor does it define outcomes. It does bring societal units with problems together with societal units with solutions. It sets up a process of communication between and among units, and then steps back—but not out. It seeks to give people the tools with which to control and change their communities or, in large urban areas, their neighborhoods. It facilitates communication between societal units, and the creation of networks and linkages between and among units where none existed before. In the course of such actions it teaches people how to use communication and networks as tools for change. Every time a horizontally linked agency encounters a family or a community group, for example, it looks for opportunities to create lines of communication, linkages between people. It may be something as simple as putting mothers with small children in touch with each other for mutual babysitting, to accommodate the needs of each for a day off.

A helping approach within this kind of context facilitates early intervention in families at high risk for drug abuse, as well as collective actions that can eliminate some of the places and contexts in which drug abuse occurs. (A community perceived by its members to be actively promoting a healthy environment, for example, will not tolerate abandoned buildings to be used as "shooting galleries," or teenage prostitution.)

Appointments and offices, representing respectively time and space, are traps to be avoided. This model assumes that personnel are available 24 hours each day and respond to calls immediately. Work is done as much as possible in the field, not in an office.

The horizontally structured service agency in the ecological model is organized as a nonprofit, community-based corporation with a

board of directors who are community residents and nonprofessionals in the mental health field. Such a corporation can receive funds from both private and public sources. Services are provided through teams of two persons: a professional and a paraprofessional, two paraprofessionals, two professionals, etc. One combination that is especially promising is a public health nurse, who understands terrain, and a social worker, who understands process. The model represents commitment to and facilitation of process. Staff develop a generalist rather than a specialist perspective, and have a particular sensitivity to and capability in fostering process. Training is ongoing; content and techniques emphasize work with *families and systems.* In summary, the ecological model describes an approach based on a fundamental rearrangement of the systems in a community, and of the relationships of the basic societal units to each other and to the community systems.

The Family Intervention Model

This model was designed to give people the tools to make improvements in interpersonal and familial contexts. It combines a psychodynamic and teaching approach, providing for informally structured family group training experiences. It seeks to reduce the sense of isolation of families, and to strengthen the sense of competency that underpins healthy family life. It is practiced within the context of the ecological model. Most of the training strategies and techniques have been used in other circumstances and are not new.

Content that has special relevance is derived from the data available from research on healthy families, plus what is known about families in which there is drug abuse. The healthy family is seen as one that has the ability to develop in children clear ideas about self, others, and family boundaries, recognizing and respecting differences as well as sameness. In general, then, training is aimed toward helping families deal with problems of boundary issues and differentiation, decisionmaking, values clarification, and interpersonal communication skills; helping them appreciate differences among family members; and strengthening the parental dyad.

With respect to parental functioning a caveat must be introduced here. Drug problems in a family too often arise because of conflict between and within subsystems, particularly within the parental subsystem. One result is that the children then develop undue power; they divide and conquer since their parents cannot present a united front. We need to be wary of assuming that parents are a unified pair who always work together, and that drug problems are simply a generation gap phenomenon. This is a trap some therapists fall into, i.e., treating the parents as a single reinforcement system rather than recognizing

that much of the problem is because the parents *cannot* work together. The sounder approach is to help parents cooperate, and to help all members recognize the contribution of the whole family when a family gets "stuck" or has a problem.

Although interventions are aimed at a population larger than that defined as "high risk," families for which there is special concern are those in which a sibling or a parent is already involved in drug abuse; families with histories of alcohol or drug abuse in one or more generations; families with immigrant parents whose first generation children are caught in conflict between the old and the new cultures; families in which there is accidental death or suicide; families in which a parent is absent due to death, desertion, or divorce. None of these factors alone will necessarily cause drug abuse, but since the presence of one or more of them is so frequently found in families in which there is drug abuse, they are seen as events that may become "stuck places" for families, and hinder the family's capabilities for enabling its members to cope in constructive ways. Training is offered around these variables that seem to be factors in drug abuse, and in this regard, content dealing with loss, and death and dying is of special concern and importance.

Providing learning experiences around critical issues in family life to a selected group of families is not in itself a sufficient answer to primary prevention on a community scale. For one thing, there are not enough trainers. Thus, what is learned by groups of families must be *practiced* in a community that shares the same understandings. Professionals can initiate change; they cannot maintain it. The maintenance of change is the job of the families who have undergone training. Families do this by being mutually reinforcing to one another in times of special need or loss, by maintaining a network of mutual aid. Training groups should promote the identification of common problems and interests so that the friendships necessary for maintaining a network can emerge. With this kind of connectedness other family support activities may be encouraged, such as devising rituals to mark changes in families and then celebrating them with all the families involved.

Families can be recruited to "well family groups"[5] through schools and churches. Training groups must be small and the families in various groups should have an opportunity to meet as many persons from other groups as possible. Methods of training are both didactic and experiential, with experiential methods considered especially necessary and probably more important. A series of seminars alone

[5] From remarks of Virginia Satir at a National Association of Social Workers workshop, Coeur d'Alene, Idaho, August 1965.

would be relatively ineffective in preventing drug abuse. In general, the training seminars are to be viewed by participant families as part of "life-as-lived" and not as "time out" from the ordinary course of life. Families must use their own lives as input for course content and not feel that they are receiving sacrosanct information from experts. Networks will not emerge if communication goes from "expert" to family in a one-way direction. Families must talk to families with similar problems, with the experts only facilitating communication. Two of the participants had been involved in similar family training programs. They reported that families are receptive to such learning, and that it was demonstrated that it reached the target populations of families with alcohol abuse. It was especially effective in church settings when there was an ethnic match between trainer and the trainee family groups. Learning experiences of this kind are popular and successful because they impart information about coping that leads the learners beyond survival to the enhancement of self-esteem and self-worth.

Professional resources, particularly family physicians, should be informed about the training groups. Funeral directors are a special community resource group that should receive training similar to that given in the death and dying seminar; they need to know when to refer families for help and what resources are available in the community. The community will need to be able to establish additional groups for families referred by others or seeking entry on their own. The family support and network features of this model operated successfully in the early years of this Nation, and their disappearance as a general way of life has been widely noted and lamented.

In order to observe and assess how families make use of the training (interventions), the model can be structured as a research project. Four categories of participants are proposed: (1) families at high risk for drug abuse, with particular emphasis on the younger siblings of drug abusers, (2) families with a psychiatric patient; (3) families with a physically ill member; (4) families in which there is no recognized problem. Four control groups can be matched to those selected for intervention.

The Media Model

The participants agreed that television is one of the biggest "pushers" in our society. Further, it often functions as another "member" of the family. As the main information source in many families, it keeps the members assembled, but not really related, around an "electronic hearth." In addition to being placed in this position within the structure of the family, television tends to blur the family hierarchy and limit parental authority because information goes equally to all

members. Thus, children become as "expert" on some subjects as their parents and, further, have "experts" other than their parents who can offer them alternate values and norms for behavior. To a child, in fact, the authority of television information can be as valid as parental information.

With special exceptions, much of what is seen on commercial television depicts, at best, an unrealistic version of family life and, at worst, works against the enhancement of healthy family life. Commercials, of course, are particular offenders in this respect, and there was speculation as to whether or not sponsoring companies will think they can sell their product if they present a more realistic picture of family life. It was generally agreed that this is possible with the high-powered promotional talent available, and that the problem is not lack of capability but insufficient motivation on the part of the large companies to play a more responsible role by using real family patterns as the background for commercials.

There are a number of ways in which television can become a powerful influence in reinforcing healthy family and personal functioning. The suggestion was made to encourage shows on commercial networks, and to provide funding for the educational network presentations, that create awareness of both healthy and unhealthy patterns of family interaction. In short spots, but with radically different content than is now offered, there is the opportunity to make people aware of our cultural tendency to use chemical problemsolvers. This gives the further opportunity to show that crisis moments in family life, if handled properly, can be opportunities for growth rather than loss. A child's first day at school, the illness or death of a family member, loss of a job can be subjects for short dramas that model successful adaptations to crisis. The important factor is to allow families to see that others have suffered the same losses, grieved, and grown, and also that others beyond the immediate family are affected. Families can be encouraged to cushion loss by turning to the wider kinship group and community. Here the use of cable television can be particularly effective. The preventive aspect of this device is to create networks in the community that can offer alternatives to ineffective solutions to family problems and make the drug-abusing lifestyle less attractive to youngsters and others in the family.

Repetitive behavior without self-awareness or control (addiction) is increasingly an aspect of modern society, and it sometimes seems as if the television industry encourages the trend. There is the rich opportunity in the medium, nonetheless, to show commonly experienced problems and constraints that impact on the growth and favorable development of families, and some of the healthy solutions to the normal difficulties in family life. Brief television spots (such as public

service announcements *presented during prime time*) can be scripted to show typical patterns seen in drug-abusing families, offering at the same time alternative ways of interacting and coping. They might identify and underscore the contributions of most or all family members to the problem, rather than singling out the "bad kid" or the "bad parents." The phenomenological perspective of each of the family members can be given, with respect to the problem behavior, to demonstrate that from each person's viewpoint he is not to blame, while the whole presentation makes clear that no one in particular is to blame, and yet *all* are responsible. Such messages will impart the information that families can get stuck at certain developmental stages, possibly resulting in a drug problem. They can also demonstrate how family systems operate successfully and how crises can be negotiated without the use of chemical problemsolvers. Television spots can also show problematic areas of family life and suggested solutions, whether drug abuse is mentioned or not.

CONCLUSION

Elaboration and implementation of the models presented here are feasible undertakings. The actuation of the models is dependent on the values, resources, and priorities of the policymakers. Lamb and Zusman (1979) describe bleak prospects as to the relative utility of primary prevention endeavors in view of current priorities that determine the allocation of scarce resources. Their focus of concern remains treatment of individuals at the tertiary end of the prevention continuum; they do not deal with the family.

The work group proposed a shift in perspective to one that acknowledges the adaptive function of the family as the societal unit with the abiding tasks of fostering and maintaining healthy coping styles among its members. They agreed with Etzioni (Salasin 1978, p.59) that a major priority for anyone concerned with promoting mental health is "the discharge of the socialization function of the family."

All the workshop participants had had long experience in the treatment of grossly dysfunctional behavior, in reparative and remedial work. For the most part, the sessions dealt with material that was familiar to them but—through the process of their deliberations—seen, approached, and rearranged into a different configuration. There was very evident excitement and enthusiasm among the group members as they turned the fullness of their professional knowledge and skills toward the primary end of the prevention continuum, achieving a re-mix of familiar elements with the fulcrum of considerations being the family unit. They voiced the lively hope that their shared endeavors would stimulate moves in new directions in the field.

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